

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
4412 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
04405									
1. PLACE OF DEATH e. COUNTY <b>Montgomery</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> P.G. <input checked="" type="checkbox"/>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanatorium &amp; Hospital</b>					d. STREET ADDRESS <b>6512 Westmorland Ave.</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Stewart</b> Last <b>Alderman</b>					4. DATE OF DEATH Month <b>Apr.</b> Day <b>25</b> Year <b>19 61</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/8/60</b>		9. AGE (In years last birthday) <b>9</b> yrs. <b>17</b> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Jerry Alderman</b>					14. MOTHER'S MAIDEN NAME <b>Judith Jordan</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If any given war or dates of service)		17. INFORMANT <b>Hosp. Record.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPHIXIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>APPARENTLY STRANGULATION</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>ASPIRATION OF GASTRIC CONTENT AND PULMONARY ATELECTASIS</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. (EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found in bed with venitean blind cord about neck</b>									
20c. TIME OF INJURY Month, Day, Year <b>3:10 p.m. 4/24/61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) <b>Takoma Pk.</b>		20g. (County) <b>P.G.</b>	
20h. (State) <b>Md.</b>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Frank J. Broschart</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <b>April 25 1961</b>				
					Address (Street, city, town, or country)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/27/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST MARY'S CEMETERY'S</b>		22d. LOCATION (City, town, or country) (State) <b>WASHINGTON, D.C.</b>			
23. FUNERAL DIRECTOR <b>W. J. Henderson</b>					24a. REC'D BY REGISTRAR <b>APR 27 '61</b>				
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>									

XXXXXXXXXX

NOV 1941  
JUL 1941



*Handwritten signature or initials.*

INITIAL

4/27/41

ST. PAUL'S CHURCH

WASHINGTON, D.C.

FROM J. PROSSER

APR 27 1941

3:15 PM

HOME

APR 27 1941

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ST. PAUL'S CHURCH

WASHINGTON, D.C.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04406

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b> c. LENGTH OF STAY IN 1b <b>1 yr.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wheaton Nursing Home</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>7900 Cypress Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>MAE FORD ANDERSON</b>			4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>19 61</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 27, 1877</b>	9. AGE (In years last birthday) <b>83 yrs.</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles Ford</b>			14. MOTHER'S MAIDEN NAME <b>Carrie Bramble</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Nursing Home Record</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>903.7</b> DUE TO <b>Fracture of Left Hip</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b> <b>18 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.V.A. 1 yr. Reported Heart Disease</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on floor after leaving bathroom at Nursing Home</b>			
20c. TIME OF INJURY Month Day Year <b>4/22/61</b> Hour a.m. <b>8:00</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nursing Home</b>	20f. (City or town) <b>Wheaton Montgomery</b>	(County) <b>Md.</b>	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>4/23/61</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>	22b. DATE THEREOF <b>4/26/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MORROW CEMETERY</b>	22d. LOCATION (City, town, or country) (State) <b>MORROW, OHIO</b>		
23. FUNERAL DIRECTOR <b>WALTER E. PUMPHREY, INC.</b> <i>Raymond E. Jaska</i>		ADDRESS <b>SILVER SPRING, MD.</b>	24a. REC'D BY REGISTRAR DATE <b>APR 26 '61</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>	

STATE OF  
NEW YORK

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NOTICE OF  
COURT PROCEEDINGS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1 & 2 Film G286 5/11/61 iwk

# CERTIFICATE OF DEATH

Reg. Dist. No.

05716

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Washington, D.C.</b> <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Sanitarium</b>		d. STREET ADDRESS <b>3100 Wisconsin Ave. N.W.</b> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LILLIAN</b> Middle <b>ARNOLD</b> Last <b>ARNOLD</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 JAN. 1879</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N.Y.</b>	
11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Arnold</b>		14. MOTHER'S MAIDEN NAME <b>Janeann Dickson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>692.5</b> DUE TO <b>pulmonary embolism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>thrombophlebitis</b> DUE TO <b>3 weeks</b> (c) <b>cellulitis right foot</b> DUE TO <b>9 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio-sclerotic cardiovascular disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-2</b> , 19 <b>60</b> , to <b>4-30</b> , 19 <b>61</b> , that I lost saw the deceased alive on <b>4-28</b> , 19 <b>61</b> , and that death occurred at <b>7:00</b> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Russell M. Tilly, Jr.</b>		ADDRESS (Street, city or town, state) <b>4701 Mass. Ave. N.W. Wash. D.C.</b>	
DATE SIGNED <b>4-30-61</b>			
PHYSICIAN'S NAME (Type) <b>Wash. D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>5-1-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematorium</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home 300-4th St. NW Wash DC</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 3 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

2000979

unsubstantiated

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

4413  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>6806 10th Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Marius Ashton</u>				4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-12-09</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>office mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>13</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert K. Ashton</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-01-2688</u>		17. INFORMANT <u>Mrs Ruth Ashton</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Acute coronary insufficiency - - minutes</u> DUE TO (b) <u>severe generalized coronary atherosclerosis -years.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u></u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-13-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 17, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Montgomery County Md</u>	
23. FUNERAL DIRECTOR <u>Arthur S. Jones</u>		ADDRESS <u>254 CARROLL ST. N.W.</u>		24. REC'D BY REGISTRAR <u>APR 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Jones</u>	

MEDICAL CERTIFICATION

IN STATE  
DEATH

(M)

(I)

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: [Illegible]  
2. Sex: [Illegible]  
3. Age: [Illegible]  
4. Date of Birth: [Illegible]  
5. Date of Death: [Illegible]  
6. Place of Death: [Illegible]  
7. Cause of Death: [Illegible]  
8. Manner of Death: [Illegible]  
9. Signature of Examiner: [Illegible]  
10. Signature of Coroner: [Illegible]  
11. Signature of Physician: [Illegible]  
12. Signature of Medical Examiner: [Illegible]  
13. Signature of Medical Examiner: [Illegible]  
14. Signature of Medical Examiner: [Illegible]  
15. Signature of Medical Examiner: [Illegible]  
16. Signature of Medical Examiner: [Illegible]  
17. Signature of Medical Examiner: [Illegible]  
18. Signature of Medical Examiner: [Illegible]  
19. Signature of Medical Examiner: [Illegible]  
20. Signature of Medical Examiner: [Illegible]

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hours after  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within  
death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral  
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should  
be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MONTGOMERY  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04408

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		d. STREET ADDRESS <b>6308 Bells Mill Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Harry C. Atkinson</b>		4. DATE OF DEATH <b>April 1 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/22/98</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>9</b> Hours <b>9</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None Aid to the Blind</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Richmond, Va</b>	
13. FATHER'S NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes-Unknown</b>	
17. INFORMANT <b>Unknown</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>8 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 years</b> <b>Osteomyelitis right tibia chronic</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/24/61</b> , 19 <b>61</b> , to <b>4/1/61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/31/61</b> , 19 <b>61</b> , and that death occurred at <b>12:45</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert N. Coale</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>4/1/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert N. Coale</b>		22d. ADDRESS <b>4630 Montg. Ave. Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/4/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>APR 5 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Bethesda, Maryland</b>		25c. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

Robert A. Pugh, Jr., Bethesda, Maryland

CERTIFICATE OF DEATH

Reg. Dist. No.

04409

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6002 Coral Sea Ave</u>		d. STREET ADDRESS <u>6002 Coral Sea Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Emily</u> First <u>None</u> Middle <u>Austin</u> Last		4. DATE OF DEATH <u>April</u> Month <u>27</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Day</u>		14. MOTHER'S MAIDEN NAME <u>Ann Low</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. P.H. Standing</u> Address <u>6002 Coral Sea</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>151X</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic H.D. &amp; atherosclerotic infection</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> 19 <u>60</u> to <u>April</u> 19 <u>61</u> , that I last saw the deceased alive on <u>April 24</u> 19 <u>61</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>809 Veirshill Rd.</u> DATE SIGNED <u>4/27/61</u> ACTUAL SIGNATURE <u>Herman Chaganzini</u> M.D. PHYSICIAN'S NAME (Type) <u>Herman Chaganzini</u> <u>Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>4/29/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 1 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Ord. 10

1. NAME OF DECEASED <i>JOHN J. HARRIS</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
6. OCCUPATION <i>Engineer</i>		7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 15 1925</i>		9. PLACE OF MARRIAGE <i>St. Louis, Mo.</i>		10. NAME OF SPOUSE <i>John J. Harris</i>	
11. CAUSE OF DEATH <i>Myocardial Infarction</i>		12. ICD-9 CODE <i>410.9</i>		13. PLACE OF DEATH <i>Home</i>		14. DATE OF DEATH <i>Jan 15 1945</i>		15. TIME OF DEATH <i>10:00 AM</i>	
16. SIGNATURE OF PHYSICIAN <i>John J. Harris</i>		17. SIGNATURE OF REGISTRAR <i>John J. Harris</i>		18. SIGNATURE OF WITNESS <i>John J. Harris</i>		19. SIGNATURE OF WITNESS <i>John J. Harris</i>		20. SIGNATURE OF WITNESS <i>John J. Harris</i>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE HEALTH COMMISSIONER, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>15</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington-Silver Spring Hospital</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12910 Colesville Road</u>	
3. NAME OF DECEASED (Type or print) <u>CAROLINE</u> First <u>O</u> Middle <u>BAKER</u> Last		4. DATE OF DEATH <u>April</u> Month <u>14</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	11. BIRTHPLACE (State or foreign country) <u>Bell Air, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>----- Osterkamp</u>	
14. MOTHER'S MAIDEN NAME <u>Marg Stanger</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mrs. Edith B. Keller</u> Address <u>12910 Colesville Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 21</u> 19 <u>60</u> , to <u>April 14</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>April 13</u> 19 <u>61</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Aaron H. Traum</u>		22b. DATE SIGNED <u>April 14 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>		22d. ADDRESS <u>8237 Georgia Avenue Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		23b. DATE THEREOF <u>April 17-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Coxville</u>		23d. LOCATION (City, town, or county) (State) <u>Coxville - Montg. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>APR 18 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04411

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>44 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Wisconsin</b> b. COUNTY <b>Superior</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>86X-3</b> d. STREET ADDRESS <b>2122 East 6th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clay</b> Middle <b>Thomas</b> Last <b>Banks</b>		4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 21, 1937</b>
9. AGE (In years last birthday) <b>23 yrs.</b>		10. IF UNDER 1 YEAR Months <b>23</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John W. Banks</b>		14. MOTHER'S MAIDEN NAME <b>Lou Lucius</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>393-32-6623</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypotension</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hodgkin's Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10 Minutes</b> <b>3 Years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 15, 1961</b> to <b>April 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 28, 1961</b> , and that death occurred at <b>5:00AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Martin J. Cline</b>		22b. DATE SIGNED <b>4-28-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Martin J. Cline M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 4-29-61</b>		23b. DATE THEREOF <b>4-29-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Solon Springs, Wis.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY :</b>		ADDRESS <b>Bethesda, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>MAY 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MONTGOMERY COUNTY, MARYLAND									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
04412									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>10 Rockville</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>115 Forest Avenue</b>					d. STREET ADDRESS <b>115 Forest Avenue</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Charles A Beard</b>					4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 61</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 9, 1882</b>		9. AGE (In years last birthday) <b>79</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Liberty Loan Treas. Dept.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William Henry Beard</b>					14. MOTHER'S MAIDEN NAME <b>Martha Abbot</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>214-28-4379A</b>				
17. INFORMANT <b>Harriet Ann Beard-Wife-Same 2d</b>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Congestive heart failure</b> DUE TO (b) <b>arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>NO</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 12, 1956</b> to <b>April 17, 1961</b> that (I) (We) last saw the deceased alive on <b>April 17, 1961</b> , and that death occurred at <b>4AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Stephen C. Cromwell</b>					22b. DATE SIGNED <b>4-17-61</b>				
22c. PHYSICIAN'S NAME (Type) <b>STEPHEN C. CROMWELL</b>					22d. ADDRESS <b>615 W. Montgomery Ave, Rockville, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4-19-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Montgomery County, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>					ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 19 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

VR A15 (4)  
15M 9/60

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112 Forest Avenue

112 Forest Avenue

Charles

Beard

April

February 2, 1942

Washington D. C. USA

Liberty Loan  
Treas. Dept.

Martha Anne

William Henry Beard

312-38-4570, Married Ann Beard-Wile-Name 24

*Handwritten notes:*  
1. *Beard, William Henry*  
2. *Beard, William Henry*  
3. *Beard, William Henry*

None

April 17

Stephen C. Brownell

STEPHEN C. BROWNELL

4-17-42

112 Forest Avenue, Rockville, Md.

4-19-42

Rockville Cemetery

Montgomery County, Md.

ROBERT A. BURNHAY

Bethesda, Md.

April 19

## CERTIFICATE OF DEATH

Reg. Dist. No. 04413

4421

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Md.</u>				c. LENGTH OF STAY IN 1b <u>7 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie Mae Benson</u>				4. DATE OF DEATH Month Day Year <u>April 14 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12, 1878</u>	
9. AGE (In years lost birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Jesse Lovell</u>				14. MOTHER'S MAIDEN NAME <u>Anna Hodges</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give year known) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
INFORMANT Address <u>Mae Beach 102 Beach Ave</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Carcinoma of Cervix</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 29, 1960</u> , to <u>April 14, 1961</u> , that I last saw the deceased alive on <u>April 14, 1961</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Corinne Cooper</u>				ADDRESS (Street, city or town, state) <u>104 S. Washington St. Rockville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Corinne Cooper</u>				DATE SIGNED <u>APR 18 '61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Neelsville Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Neelsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>				24a. REC'D BY REGISTRAR <u>1331 E. Montgomery Ave. Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0-113

MINISTRY OF HEALTH

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 46</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS SAN.</u>				d. STREET ADDRESS <u>5825 Zikston Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Isadora</u> Middle <u>-</u> Last <u>Bornstein.</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 19, 1889</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>	IF UNDER 24 HRS. Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GLOVE CUTTER -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Meyer Bornstein (Dec)</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Engerman (Dec)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>HARRY BORNSTEIN</u> Address <u>BETH. MD 5825 FOLKSTONE RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of bladder.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>60</u> to <u>Apr 28</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Apr 28</u> 19 <u>61</u> , and that death occurred at <u>10:25 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Blaine H. E. G. M. D.</u>				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 28, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. E. G. M. D.</u>				22d. ADDRESS <u>8641 Cleveland Rd Silver Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/30/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR PARK Cem</u>		23d. LOCATION (City, town, or county) (State) <u>PARAMUS, N. J.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deakery Funeral Home 4217-9</u>				25a. REC'D BY REGISTRAR <u>May 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knease</u>	

CERTIFICATE OF DEATH

1914

11

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4423

04415

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>13 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>58 Cabin John, Bethesda</u> d. STREET ADDRESS <u>111 Mc Kay Circle</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Justinus</u> <b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>10</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12/6/06</u> <b>9. AGE</b> (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Food Salesman</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Woodward &amp; Lothrop</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Amsterdam</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A Since 1960</u>		<b>13. FATHER'S NAME</b> <u>Bosdriesz</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Voorveld</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>  </u> <b>16. SOCIAL SECURITY NO.</b> <u>527-42-1045</u> <b>17. INFORMANT</b> <u>Bosdriesz</u> <u>Wife Kornelia Bosdriesz (Same as Above)</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Obstruction of small intestine due to tumor</u> DUE TO (b) <u>Adenocarcinoma of kidney with widespread metastases</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>6 months</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/7</u> <u>1961</u> , to <u>4/10/61</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>Apr 9</u> , 19 <u>61</u> , and that death occurred at <u>2:30</u> A.M., from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <u>Stephen W. Deijter</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Stephen W. Deijter</u>		<b>22b. DATE SIGNED</b> <u>4/10/61</u> <b>22d. ADDRESS</b> <u>6719 Wilson Lane, Bethesda, Maryland</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>4/12/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GATE OF HEAVEN CEMETERY</u> <b>23d. LOCATION</b> (City, town or county) <u>MONTGOMERY COUNTY, MARYLAND</u> (State) <u>  </u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond A. Ziska</u> <b>25a. REC'D BY REGISTRAR</b> <u>APR 13 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>		<b>25c. ADDRESS</b> <u>SILVER SPRING, MD.</u>	

1990

• **TRANSDUCERS** •

2451 S. YOUNG

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 04416

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Somerset</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Somerset</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4717 Falstone Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GERTRUDE L. BRADLEY</u>		4. DATE OF DEATH <u>APRIL 13 1961</u>	
5. SEX <u>R</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/13/84</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William R. Lebert</u>		14. MOTHER'S MAIDEN NAME <u>Lovina Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. John C. Lang</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOGARDIAL DEGENERATION</u> 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u>CHR LYMPHOCYTIC LEUKEMIA</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 WK +</u> <u>1 YR +</u> <u>7 YR.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEP 1960</u> to <u>APR 1961</u> , that I last saw the deceased alive on <u>APR 12 1961</u> , and that death occurred at <u>1:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1635 HARVARD ST</u> DATE SIGNED <u>Wyrth Post Baker</u>			
ACTUAL SIGNATURE <u>Wyrth Post Baker</u> M.D. <u>1635 HARVARD ST</u>			
PHYSICIAN'S NAME (Type) <u>WYRTH POST BAKER, WASH. 9 DC.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/15/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines C.</u>		24a. REC'D BY REGISTRAR <u>DATE APR 14 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4425

04417

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Sumner Hills</u> c. LENGTH OF STAY IN 1b <u>9 mo.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Sumner Hills</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5052 Westpath Ter</u>				d. STREET ADDRESS <u>5052 Westpath Ter</u>			
3. NAME OF DECEASED (Type or print) <u>Warren Spencer Breninger</u>				4. DATE OF DEATH <u>Apr 14</u> 19 <u>61</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-5-1896</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>excavation</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>Warren F. Breninger</u>				14. MOTHER'S MAIDEN NAME <u>Mabel G. Thorne</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>4-14-61</u>			
17. INFORMANT <u>Marie Breninger (wife)</u>				Address <u>Stem 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) <u>History of previous heart attacks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4-14-61</u>			
22a. BURIAL, CREMATION, REMOVAL <u>burial</u>		22b. DATE THEREOF <u>4/17/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR <u>The S.H. Hines Co., 2901 14th St. N.W., Wash, DC</u>				24a. REC'D BY REGISTRAR <u>APR 17 '61</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

252

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04418

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>15 days</b>		d. STREET ADDRESS <b>5442 Broad Branch Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles V Broadley</b>		OF DEATH <b>April 21 19 61</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/14/1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Gov't</b>		9. AGE (In years last birthday) <b>58</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <b>John Broadley</b>		14. MOTHER'S MAIDEN NAME <b>Harriet White</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>059-104722</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>584X</b> DUE TO <b>Respiratory Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Circulatory Collapse</b> <b>Acute Hemorrhagic Pancreatitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>30 hrs.</b> <b>6 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cholelithiasis &amp; Cholecystectomy 4/12/61</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 4/20 19 61</b> to <b>4/21 19 61</b> , that (I) (we) last saw the deceased alive on <b>4/20 19 61</b> , and that death occurred at <b>3:22 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank J. Jagger Jr.</b> M.D.		22b. DATE SIGNED <b>4/21/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frank J. Jagger Jr.</b>		22d. ADDRESS <b>5707 Wisconsin Ave Chevy Chase 15, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/25/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 25 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hoad</b>	



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*Handwritten notes, mostly illegible due to blurring and bleed-through. Some words like "Project" and "Fingerprint" are visible.*

*Handwritten notes at the bottom of the page, including "April 21" and "Fingerprint".*

Bp

# CERTIFICATE OF DEATH

04419

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>619 C Street, N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roxie</b> Middle <b>(None)</b> Last <b>Broadnax</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1910</b>
9. AGE (In years lost birthday) yrs. <b>51</b>		10. IF UNDER 1 YEAR Months <b>51</b> Days <b>17</b> Hours <b>50</b> Min. <b>17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Willie Carter</b>		14. MOTHER'S MAIDEN NAME <b>Missouri Walker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>230-16-3130</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ovarian Carcinoma Metastatic to the Brain</b> DUE TO <b>175.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Ovary</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 Weeks</b> <b>18 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>April</b> Day <b>28</b> Year <b>1961</b> Hour <b>8</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Huntsville</b> (County) <b>Madison</b> (State) <b>Alabama</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>April 28, 1961</b> to <b>April 30, 1961</b> , that (I) (we) lost saw the deceased alive on <b>April 30, 1961</b> , and that death occurred on <b>April 30, 1961</b> at <b>8:05 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Donald L. Morton</b>		22b. DATE SIGNED <b>5/2/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DONALD L. MORTON, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-8-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>		23d. LOCATION (City, town, or county) <b>Huntsville, Maryland</b> (State) <b>Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>MALVAN &amp; SCHEY, INC.</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 8 '61</b>	
ADDRESS <b>424 "R" St., N. W.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>	

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VETERANS AFFAIRS  
OFFICE OF THE ASSISTANT SECRETARY  
WASHINGTON, D. C. 20460

100-1-1001

(M)

1. Name of Patient: \_\_\_\_\_

2. Date of Birth: \_\_\_\_\_

3. Date of Admission: \_\_\_\_\_

4. Date of Discharge: \_\_\_\_\_

5. Date of Death: \_\_\_\_\_

6. Date of Burial: \_\_\_\_\_

7. Date of Interment: \_\_\_\_\_

8. Date of Cremation: \_\_\_\_\_

9. Date of Reinterment: \_\_\_\_\_

10. Date of Final Disposition: \_\_\_\_\_

11. Date of Final Disposition: \_\_\_\_\_

12. Date of Final Disposition: \_\_\_\_\_

13. Date of Final Disposition: \_\_\_\_\_

14. Date of Final Disposition: \_\_\_\_\_

15. Date of Final Disposition: \_\_\_\_\_

16. Date of Final Disposition: \_\_\_\_\_

17. Date of Final Disposition: \_\_\_\_\_

18. Date of Final Disposition: \_\_\_\_\_

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04420

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>33 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> d. STREET ADDRESS <u>Route # 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Eliza Jane Brown</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>April 24</u> 19 <u>61</u> Month Day Year							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>col.</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8/7/16</u>		<b>9. AGE</b> (In years lost birthday) <u>44</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>											
<b>13. FATHER'S NAME</b> <u>Ulysses Henry</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Della</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>216-30-4950</u>				<b>17. INFORMANT</b> <u>Husband (Carlton Wm. Brown)</u> Address <u>Same as above</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-intestinal bleeding, recurrent</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>Esophageal varices</u> DUE TO (c) <u>Cirrhosis of Liver</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. 19 <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>22 March 1961</u> <b>to</b> <u>24 April 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>23 April 1961</u> <b>and that death occurred at</b> <u>204</u> <b>M, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Richard C. Myers</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Richard C. Myers</u>						<b>22b. DATE SIGNED</b> <b>22d. ADDRESS</b> <u>8512 Old Georgetown Rd., Bethesda, Md.</u>					
<b>23a. BURIAL, CREMATION, REMAINS</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>4/28/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National., Arlington, Va.</u>				<b>23d. LOCATION (City, town, or county)</b> (State) <u>Arlington, Va.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert L. Snowden</u>						<b>ADDRESS</b> <u>Rockville, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>APR 28 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11/1/50

CERTIFICATE OF DEATH

11/1/50

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ROBERT C. WHITE  
4/28/51  
Arlington National, Arlington, Va.  
Rockville, Md.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 04421

4429

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>10 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>109 SUNNYSIDE ROAD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BETTY</b> Middle <b>WILSON</b> Last <b>BUCHANAN</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>14</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/11/93</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Buyer (retired) Art Dept.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Dept. Stores</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK STATE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CHARLES L. WILSON</b>				14. MOTHER'S MAIDEN NAME <b>ANNA MANTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-10-5178</b>		INFORMANT Address <b>Mr. John Raymond Buchanan, 109 Sunnyside Road Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Ovary</b> <b>1750</b> DUE TO <b>Metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>12-15 mo.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1956</b> , to <b>14 April 1961</b> , that I last saw the deceased alive on <b>13 April 1961</b> , and that death occurred at <b>2:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9006 Collesville Rd Silver Spring, Md.</b> DATE SIGNED <b>4/14/61</b> ACTUAL SIGNATURE <b>William D. Aud</b> M.D. <b>William D. Aud</b> PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/18/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WANNER E. PUMPHREY, INC.</b> <b>Raymond A. Giska</b>				24a. REC'D BY REGISTRAR DATE <b>APR 19 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3515-01-119

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
c. LENGTH OF STAY in lb <u>1 mo</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Williams Fitzhugh Burgess</u>		4. DATE OF DEATH Month Day Year <u>Apr 16 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-86</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>dry cleaning</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm H. Burgess</u>		14. MOTHER'S MAIDEN NAME <u>Willie Ann Bryan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-05-4804</u>	
17. INFORMANT <u>Mary Burgess (wife)</u>		Address <u>Itan 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma - years</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-16-61</u>	
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-19-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or country) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR <u>Tobias A. Mattingly</u>		24. REC'D BY REGISTRAR <u>131-1118882</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>		DATE <u>APR 18 '61</u>	

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND RECORDS DIVISION  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
DEPARTMENT

(M)

(1)

511-09-184

11-11-1911  
D. B. Walsh  
Compressor  
11-11-1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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4431

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04423

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 88 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville 48X-2 d. STREET ADDRESS 334 E. Monroe Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Peggy		4. DATE OF DEATH April 27 1961	
5. SEX Female		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-27-30	
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (County & State, or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown JAMES		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 267-66-9057	
17. INFORMANT (H) Thomas B. Burke, IC2, USN, USS SATATOGA, c/o FPO, New York		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 171X } DUE TO (b) Renal Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Squamous cell Carcinoma Cervix Uteri PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 1 day 3 mo 1 yr. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Jan. 29, 1961, to April 27, 1961 that (X) (we) last saw the deceased alive on April 27, 1961, and that death occurred at 4:10 PM, from the causes and on the date stated above.			
22a. SIGNATURE R. F. Mading		22b. DATE SIGNED 4-28-61	
22c. PHYSICIAN'S NAME (Type) R. F. MADING, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-2-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home, Rockville, Md.		25a. REC'D BY REGISTRAR DATE MAY 2 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04424

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colmar Manor</i> <i>1644-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Sanitorium</i>		d. STREET ADDRESS <i>3408 42Nd. Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>MOSBY</i> Middle <i>A.</i> Last <i>BUTT</i>		4. DATE OF DEATH Month <i>APRIL</i> Day <i>10</i> Year <i>1961</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11 MAY 1877</i>
9. AGE (In years last birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jno Henry Butt</i>		14. MOTHER'S MAIDEN NAME <i>Ida I. Ricketts</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT Address <i>Matilda E. Ricketts 10801 Hunting Lane, Rock, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i> 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hydrothorax - right</i> DUE TO (c) <i>Chronic Congestive Heart Failure</i>			INTERVAL BETWEEN ONSET AND DEATH <i>18 hrs</i> <i>2 mos.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Congestive - progressive - feet - arteriosclerosis.</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1960</i> to <i>Apr 10, 1961</i> , that (I) (we) last saw the deceased alive on <i>Mar 28 1961</i> , and that death occurred at <i>12 noon</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert T. Thibadeau</i>		22b. DATE SIGNED <i>Apr 10-1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT T. THIBADEAU</i>		22d. ADDRESS <i>KENSINGTON, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4/13/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Potomac Church Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Potomac, Maryland</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler</i> ADDRESS <i>1331 East Montgomery Ave. Rock, Md</i>		25a. REC'D BY REGISTRAR <i>APR 13 '61</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

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JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04425

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>4 1/2 hrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Carroll</b> Last <b>Carroll</b>				4. DATE OF DEATH Month <b>Apr.</b> Day <b>27</b> Year <b>1961</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>col.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/1/1918</b>	
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>7</b>		IF UNDER 24 HRS. Hours <b>2</b> Min. <b>3</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John Carroll</b>				14. MOTHER'S MAIDEN NAME <b>Dottie Thomas</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Herniation of brain stem</b> DUE TO <b>452X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral edema</b> DUE TO (c) <b>Ruptured aneurysm, Anterior communicating artery</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>6 hours</b> <b>6 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschert</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschert</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>4-28-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
<b>Burial</b>		<b>2 May 1961</b>		<b>Church Cemetery</b>		<b>Newberg, Maryland</b>	
23. FUNERAL DIRECTOR <b>Killie E. Amwood</b>				24a. REC'D BY REGISTRAR <b>4609-14th St N.W.</b>			
ADDRESS <b>Washington, D.C.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

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John Carroll.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4434

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04426

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>55</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>4721 Drummond Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Bernard</b> Last <b>Carry</b>		4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1889</b> 9. AGE (In years last birthday) <b>71</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chestnut Farms Dairy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired.</b>	
11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Luke Carry</b>		14. MOTHER'S MAIDEN NAME <b>Mary McNamee</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes Unknown</b>	
17. INFORMANT <b>Wife</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>April 5, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/8/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Silver Spring, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 10 61</b> DATE	24b. REGISTRAR'S SIGNATURE <b>Arthur D. Hanna</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4435

04427

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>4611 Montgomery Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Thomas James CHACONAS</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>April 26 19 61</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>9-1-06</b>		9. AGE (in years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Broker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>James K. CHACONAS</b>				14. MOTHER'S MAIDEN NAME <b>Virginia B. BOORAS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>1943 to 1945</b>				17. INFORMANT Address <b>(W) Mrs. Nancy H. Chaconas, same as #2 above</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage</b> 204.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Monocytic Leukemia</b> (e), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>  <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 15 1961</b> to <b>April 26, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 26 1961</b> , and that death occurred at <b>6:02 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>R. G. MUTH, LT, MC, USN</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4-27-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>R. G. MUTH, LT, MC, USN</b>						22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1 May 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>				23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hyson's Funeral Home</b>						ADDRESS <b>Hyson's Funeral Home, 1300 N St., NW, WashDC</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kiana</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(11-11-11)

U. S. Naval Hospital

Washington

Naval Hospital

Washington, D. C.

Virginia B. Rogers

1914 to 1915

(7) Mrs. Mary A. Rogers, 1914 to 1915

Hygiene Division, 1914 to 1915, Washington

Virginia B. Rogers

1914 to 1915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4436

04428

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN lb <b>3 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2666 Cory Terrace</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>2666 Cory Terrace</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ADALINE FORD CLARK</b>		4. DATE OF DEATH Month <b>4</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/3/79</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>18</b> Hours <b>1961</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CLARKSBURG, WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL FORD</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE KENNEDY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. Martin L. Ford, 4007 Southend Rd. Rockville, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO (b) <b>Extreme tachypnea</b> DUE TO (c) <b>Carcinomatosis</b> Conditions, if any, which 90% rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Osteoporosis malabsorption</b> INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>18 mo</b> <b>18 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 4-17 1958</b> to <b>April 1961</b> , that (I) (we) last saw the deceased alive on <b>4-17 1961</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Richard P. Delaney</b> M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <b>RICHARD P. DELANEY</b> 22d. ADDRESS <b>4323 Harvard St. Ld Sps, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		23b. DATE THEREOF <b>4/22/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>FAIRMONT, WEST VIRGINIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, Inc.</b> <b>Raymond A. Ziska</b>		25a. REC'D BY REGISTRAR <b>APR 21 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G286 5/3/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

04429

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMORELAND HILLS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMORELAND HILLS, MARYLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4515-WETHERILL ROAD</b>		d. STREET ADDRESS <b>4515-WETHERILL ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>C.</b> Last <b>CLARK</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/28/1862</b>
9. AGE (In years last birthday) <b>98</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>29</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MEDICINE</b>	
11. BIRTHPLACE (State or foreign country) <b>SCHELLSBURG, PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM ALEXANDER BOYD CLARK</b>		14. MOTHER'S MAIDEN NAME <b>JANE LARUE RAMSEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>HELEN L. CLARK</b>		Address <b>Westmoreland</b> <b>4515 WETHERILL RD. Hills</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>20 YRS. PLUS</b> <b>EXACT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1937</b> , to <b>APRIL 26, 1961</b> , that I last saw the deceased alive on <b>APRIL 26, 1961</b> , and that death occurred at <b>7:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1801-EYE STREET, N.W.</b> DATE SIGNED <b>APRIL 26, 1961</b>			
ACTUAL SIGNATURE <b>Alan Frank Kreglow</b> M.D.		DATE SIGNED <b>APRIL 26, 1961</b>	
PHYSICIAN'S NAME (Type) <b>DR. ALAN FRANK KREGLOW, M.D.</b>		ADDRESS (Street, city or town, state) <b>1801 EYE STREET, N.W. - WASH. D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 1/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>SUITLAND, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>MARTIN W. HYSOYNG CO.</b>		24a. REC'D BY REGISTRAR <b>MAY 1 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			



1. PLACE OF DEATH a. COUNTY <b>Mont.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Mont.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beth.</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney Acres Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>				d. STREET ADDRESS <b>17712 Ridge Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Earl Compton</b>		4. DATE OF DEATH <b>4 17 19 61</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/2/16</b>	9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Roof Const. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Perry Compton</b>		14. MOTHER'S MAIDEN NAME <b>Missouri Gilbert</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. 2 577-32-3074</b>		17. INFORMANT <b>Robert Compton (brother) same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Poisoning</b> <b>8923</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>Found asleep in truck</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Truck was being heated by lead melting pot which burns charcoal. Found asleep in truck.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>4/17 19 61</b> ? p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Const. Co. Plant</b>	
		20f. (City or town) <b>Rockville</b>		(County) <b>Mont.</b>	
				(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank A. Broschart</b>		EXAMINER'S NAME (Type) <b>Frank A. Broschart</b>		DATE SIGNED <b>4/17/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/20/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arl. Nat'l Cem.</b>	
				22d. LOCATION (City, town, or country) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 20 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04431

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>3000 McConnae Ave</i>		c. LENGTH OF STAY IN 1b <i>2 yrs</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring,</i>		d. STREET ADDRESS <i>109 North wood Ave</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>FRANCIS</i> Middle <i>E</i> Last <i>Cooksey</i>		4. DATE OF DEATH Month <i>April</i> Day <i>12</i> Year <i>1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 30 1884</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shipping Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Charles Town Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>Charles Town Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Francis Brown Cooksey</i>		14. MOTHER'S MAIDEN NAME <i>Serena Price Charles Co. Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Lune Knapp</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden Heart Failure</i> 450.0 DUE TO <i>Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pericarditis (4/2/57)</i> DUE TO <i>Anteroseptal myocardial infarction</i> (c) <i>Anteroseptal myocardial infarction</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/3/59</i> , 19___, to <i>4/12/61</i> , 19___, that I last saw the deceased alive on <i>4/12/61</i> , 19___, and that death occurred at <i>5 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Samuel Allen M.D.</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>4/12/61</i>	
PHYSICIAN'S NAME (Type) <i>Samuel Allen M.D.</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>4-15-61</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Silver Spring Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel Allen M.D.</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>APR 14 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

CERTIFICATE OF DEATH

1932

FILE NO. 1111

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of birth: <i>Jan 15 1887</i></p>	
<p>5. Place of birth: <i>John Doe</i></p>		<p>6. Date of death: <i>Dec 10 1932</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Place of death: <i>John Doe</i></p>	
<p>9. Signature of physician: <i>John Doe</i></p>		<p>10. Signature of registrar: <i>John Doe</i></p>	
<p>11. Signature of informant: <i>John Doe</i></p>		<p>12. Signature of witness: <i>John Doe</i></p>	
<p>13. Signature of registrar: <i>John Doe</i></p>		<p>14. Signature of witness: <i>John Doe</i></p>	
<p>15. Signature of registrar: <i>John Doe</i></p>		<p>16. Signature of witness: <i>John Doe</i></p>	
<p>17. Signature of registrar: <i>John Doe</i></p>		<p>18. Signature of witness: <i>John Doe</i></p>	
<p>19. Signature of registrar: <i>John Doe</i></p>		<p>20. Signature of witness: <i>John Doe</i></p>	
<p>21. Signature of registrar: <i>John Doe</i></p>		<p>22. Signature of witness: <i>John Doe</i></p>	
<p>23. Signature of registrar: <i>John Doe</i></p>		<p>24. Signature of witness: <i>John Doe</i></p>	
<p>25. Signature of registrar: <i>John Doe</i></p>		<p>26. Signature of witness: <i>John Doe</i></p>	
<p>27. Signature of registrar: <i>John Doe</i></p>		<p>28. Signature of witness: <i>John Doe</i></p>	
<p>29. Signature of registrar: <i>John Doe</i></p>		<p>30. Signature of witness: <i>John Doe</i></p>	
<p>31. Signature of registrar: <i>John Doe</i></p>		<p>32. Signature of witness: <i>John Doe</i></p>	
<p>33. Signature of registrar: <i>John Doe</i></p>		<p>34. Signature of witness: <i>John Doe</i></p>	
<p>35. Signature of registrar: <i>John Doe</i></p>		<p>36. Signature of witness: <i>John Doe</i></p>	
<p>37. Signature of registrar: <i>John Doe</i></p>		<p>38. Signature of witness: <i>John Doe</i></p>	
<p>39. Signature of registrar: <i>John Doe</i></p>		<p>40. Signature of witness: <i>John Doe</i></p>	
<p>41. Signature of registrar: <i>John Doe</i></p>		<p>42. Signature of witness: <i>John Doe</i></p>	
<p>43. Signature of registrar: <i>John Doe</i></p>		<p>44. Signature of witness: <i>John Doe</i></p>	
<p>45. Signature of registrar: <i>John Doe</i></p>		<p>46. Signature of witness: <i>John Doe</i></p>	
<p>47. Signature of registrar: <i>John Doe</i></p>		<p>48. Signature of witness: <i>John Doe</i></p>	
<p>49. Signature of registrar: <i>John Doe</i></p>		<p>50. Signature of witness: <i>John Doe</i></p>	
<p>51. Signature of registrar: <i>John Doe</i></p>		<p>52. Signature of witness: <i>John Doe</i></p>	
<p>53. Signature of registrar: <i>John Doe</i></p>		<p>54. Signature of witness: <i>John Doe</i></p>	
<p>55. Signature of registrar: <i>John Doe</i></p>		<p>56. Signature of witness: <i>John Doe</i></p>	
<p>57. Signature of registrar: <i>John Doe</i></p>		<p>58. Signature of witness: <i>John Doe</i></p>	
<p>59. Signature of registrar: <i>John Doe</i></p>		<p>60. Signature of witness: <i>John Doe</i></p>	
<p>61. Signature of registrar: <i>John Doe</i></p>		<p>62. Signature of witness: <i>John Doe</i></p>	
<p>63. Signature of registrar: <i>John Doe</i></p>		<p>64. Signature of witness: <i>John Doe</i></p>	
<p>65. Signature of registrar: <i>John Doe</i></p>		<p>66. Signature of witness: <i>John Doe</i></p>	
<p>67. Signature of registrar: <i>John Doe</i></p>		<p>68. Signature of witness: <i>John Doe</i></p>	
<p>69. Signature of registrar: <i>John Doe</i></p>		<p>70. Signature of witness: <i>John Doe</i></p>	
<p>71. Signature of registrar: <i>John Doe</i></p>		<p>72. Signature of witness: <i>John Doe</i></p>	
<p>73. Signature of registrar: <i>John Doe</i></p>		<p>74. Signature of witness: <i>John Doe</i></p>	
<p>75. Signature of registrar: <i>John Doe</i></p>		<p>76. Signature of witness: <i>John Doe</i></p>	
<p>77. Signature of registrar: <i>John Doe</i></p>		<p>78. Signature of witness: <i>John Doe</i></p>	
<p>79. Signature of registrar: <i>John Doe</i></p>		<p>80. Signature of witness: <i>John Doe</i></p>	
<p>81. Signature of registrar: <i>John Doe</i></p>		<p>82. Signature of witness: <i>John Doe</i></p>	
<p>83. Signature of registrar: <i>John Doe</i></p>		<p>84. Signature of witness: <i>John Doe</i></p>	
<p>85. Signature of registrar: <i>John Doe</i></p>		<p>86. Signature of witness: <i>John Doe</i></p>	
<p>87. Signature of registrar: <i>John Doe</i></p>		<p>88. Signature of witness: <i>John Doe</i></p>	
<p>89. Signature of registrar: <i>John Doe</i></p>		<p>90. Signature of witness: <i>John Doe</i></p>	
<p>91. Signature of registrar: <i>John Doe</i></p>		<p>92. Signature of witness: <i>John Doe</i></p>	
<p>93. Signature of registrar: <i>John Doe</i></p>		<p>94. Signature of witness: <i>John Doe</i></p>	
<p>95. Signature of registrar: <i>John Doe</i></p>		<p>96. Signature of witness: <i>John Doe</i></p>	
<p>97. Signature of registrar: <i>John Doe</i></p>		<p>98. Signature of witness: <i>John Doe</i></p>	
<p>99. Signature of registrar: <i>John Doe</i></p>		<p>100. Signature of witness: <i>John Doe</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4440  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04432

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2101 HILDAROSE DRIVE</b>				d. STREET ADDRESS <b>2101 HILDAROSE DRIVE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>MAE</b> Last <b>COOLEY</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 6, 1876</b>	
9. AGE (In years lost birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE W. DONN</b>				14. MOTHER'S MAIDEN NAME <b>ELLEN M. COURTNEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>Mr. Harry D. Cooley, 2101 Hildarose Dr., Apt. 102 Silver Spring, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Vascular Hemorrhage</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 1960</b> to <b>April 7, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 6, 1961</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Edward J. Richards</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/10/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PUMPEY, INC. Raymond A. Ziska</b>				25a. REC'D BY REGISTRAR DATE <b>APR 11 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

CERTIFICATE OF DEATH

0000

(M)

X

(1)

MASSACHUSETTS DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS  
BOSTON, MASSACHUSETTS

NAME: [REDACTED]  
AGE: [REDACTED]  
SEX: [REDACTED]  
DATE OF BIRTH: [REDACTED]  
DATE OF DEATH: [REDACTED]  
PLACE OF BIRTH: [REDACTED]  
PLACE OF DEATH: [REDACTED]  
CAUSE OF DEATH: [REDACTED]  
MANNER OF DEATH: [REDACTED]  
OCCUPATION: [REDACTED]  
EDUCATION: [REDACTED]  
RELIGION: [REDACTED]  
MARRIAGE: [REDACTED]  
SIGNED: [REDACTED]  
DATE: [REDACTED]

CERTIFICATE OF DEATH

Reg. Dist. No. 04433

4441

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> 34	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12012 VALLEYWOOD DRIVE</u>		d. STREET ADDRESS <u>12012 VALLEYWOOD DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>FRANCIS</u> Last <u>COURTNEY</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 3 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>	
11. BIRTHPLACE (State or foreign country) <u>BOSTON MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MRS WILLIE COURTNEY</u> Address <u>12012 Valleywood Dr Wheaton Md.</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Congestion</u> DUE TO (c) <u>HYPERTENSIVE Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES.</u> <u>TWO MONTHS</u> <u>5 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Lung Abscess, Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 1955</u> , to <u>April 10 1961</u> , that I last saw the deceased alive on <u>April 10 1961</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>JACK CROWELL</u>		ADDRESS (Street, city or town, state) <u>2025 EYE STREET N.W. Washington D.C.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JACK CROWELL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-13-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u> ADDRESS <u>3072-M-Sp.N.W.</u>		24a. REC'D BY REGISTRAR <u>DATE APR 12 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04434

4442

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>24 days</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>39 Silver Spring</u> d. STREET ADDRESS <u>1903 August Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles R Cox</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>10</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>March 3, 1899</u>			
<b>9. AGE</b> (In years last birthday) <u>61</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Operator</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington D.C.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Edward Cox</u>		<b>14. MOTHER'S M maiden name</b> <u>Desigienra Webster</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes.</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Bertha I Cox (sister)</u> Address <u>(same as above)</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> DUE TO <u>410X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonic heart disease - aortic stenosis &amp; insufficiency</u> DUE TO <u>and</u> (c) <u>Arteriosclerotic heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>Known</u> <u>10 years</u> <u>Known</u> <u>10 years</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. _____ Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>April 9, 1961</u> to <u>April 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 9, 1961</u> , and that death occurred at <u>12:48 P.M.</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Carson H. Trau</u> M.D.				<b>22b. DATE SIGNED</b> <u>April 10, 1961</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type)				<b>22d. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4-13-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Congressional Cemetery Washington, D.C.</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Washington, D.C.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>APR 14 '61</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Desel Funeral Home</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Trau</u>		<b>25c. ADDRESS</b> <u>4812 9th Ave N.W. Wash. D.C.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11

1

Montgomery  
Bethesda  
Seaboard Hospital  
Charles R  
Male White  
Operator  
Elmer Cof

24 days

Cox

Montgomery  
Silver Spring  
1903 August Drive  
April 10 1911  
Mail 8 1911  
Washington D.C.  
Bessie White

Butter 10 (white) (same as above)

4-13-11

10 FEB 11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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4443  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04435

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 10 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 458 Oak Wood Street, S. W.			
3. NAME OF DECEASED (Type or print) Jeffrey David CRAIG		4. DATE OF DEATH April 21 19 61		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-61	9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 9 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Robert M. CRAIG		14. MOTHER'S MAIDEN NAME Judith Irene SILER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Robt. M. Craig, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 773.5 DUE TO 773.5 DUE TO		Hyaline Membrane Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from April 20, 1961, to April 21, 1961, that (4) (we) last saw the deceased alive on April 21, 1961, and that death occurred at 8:10AM, from the causes and on the date stated above.					
22a. SIGNATURE Fred W. Grello		22b. DATE 4-21-61		22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-25-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) Arlington		23e. (State) Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., 517 11th St. SE, WashDC		25a. REC'D BY REGISTRAR DATE APR 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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U. S. Chamber of Commerce, 211 Fifth Avenue, New York

Branch

4-22-41

Washington National

Division on

Virginia

John W. Graham, Jr., New York

U. S. Naval Hospital, Bethesda, Md.

4-21-41

(2) Robert W. Graham, New York

Robert W. Graham

United States

Division

4-20-41

USA

U. S. Naval Hospital

Branch (1)

Washington

Division of

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Conn</i> b. COUNTY <i>New Haven</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>2 mo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Nursing Home</i>		d. STREET ADDRESS <i>Naugatuck</i>	
3. NAME OF DECEASED (Type or print) First <i>Anne</i> Middle <i>Teresa</i> Last <i>Cross</i>		4. DATE OF DEATH Month <i>Apr.</i> Day <i>1</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 15 1978</i>
9. AGE (In years last birthday) <i>82</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William F. Kehoe</i>		14. MOTHER'S MAIDEN NAME <i>Mary Brennan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>3229 Morris St D.C.</i>	
17. INFORMANT <i>Capt. Wm H. Cross</i>		Address <i>Washington, D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i> <i>years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 29 1960</i> to <i>April 1 1961</i> , that (I) (we) last saw the deceased alive on <i>April 1 1961</i> , and that death occurred at <i>11:30 PM</i> , from the causes and on the date stated above.			
22. SIGNATURE <i>Robert B. Havell</i>		22b. DATE SIGNED <i>4-1-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert B. Havell</i>		22d. ADDRESS <i>5516 Neb. Ave - DC.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-4-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St James</i>		23d. LOCATION (City, town, or county) (State) <i>New Haven County Conn.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A Pumphrey</i>		25a. REC'D BY REGISTRAR DATE <i>APR 6 '61</i>	
ADDRESS <i>7557 Wisc Ave Beth Md</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hana</i>	

11-23-61

CERTIFICATE OF MARRIAGE

11-23-61

11-23-61

Central National Bank  
Central National Bank

Robert D. Howell  
April 1, 1961  
April 1, 1961  
April 1, 1961

New Haven County Court  
April 1, 1961  
April 1, 1961  
April 1, 1961

4445

4445

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04437

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
c. LENGTH OF STAY IN 1b <i>Life</i>		d. STREET ADDRESS <i>205 Martin Lane</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lottie Marie Gutchfield</i>		4. DATE OF DEATH Month <i>4</i> Day <i>25</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 28, 1888</i>
9. AGE (In years lost birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Isaac Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte (unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Pauline Ellison daughter</i>		Address <i>16 Moore Dr. Rockville Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary Occlusive Disease</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <i>6-12</i> 19 <i>60</i> to <i>4-25</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>4-25</i> 19 <i>61</i> , and that death occurred at <i>10:30 A</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Oliver E. Jackson</i>		22b. DATE SIGNED <i>4-25-61</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>202 Martin Lane, Rockville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/27/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Haiti.</i>		23d. LOCATION (City, town, or county) (State) <i>Rockville, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Suroden</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 2 '61</i>	
ADDRESS <i>Rockville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

UNITED STATES OF AMERICA

1912

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Rockville, Md.

Rockville, Md.

Rockville, Md.

Rockville, Md.

Rockville, Md.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4446 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04438

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u>			
c. LENGTH OF STAY IN lb <u>1 wk</u>				d. STREET ADDRESS <u>82X-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Acorn Acres Nursing Home</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Molly P. Cummings</u>				4. DATE OF DEATH <u>Apr 23 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-23-15</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>va</u>			
11. BIRTHPLACE (State or foreign country) <u>va</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>William E. Williams</u>				14. MOTHER'S MAIDEN NAME <u>May Pindoney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Nursing Home Record</u>			
17. INFORMANT <u>Nursing Home Record</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebral failure</u>							
153.9 DUE TO (b) <u>C. A. of upper intestinal tract with metastases</u>							
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				4-24-61			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/26/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>US National</u>		22d. LOCATION (City, town, or country) (State) <u>Annapolis md</u>	
23. FUNERAL DIRECTOR <u>Bernard Hurdady</u> ADDRESS <u>Salisbury, Md</u>				24a. REC'D BY REGISTRAR <u>May 2 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

MEDICAL CERTIFICATION



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS NURSING HOME</b>		d. STREET ADDRESS <b>3802 THORNAPPLE STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Albert</b> Last <b>Davis</b>		4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1861</b>
9. AGE (In years lost birthday) <b>99</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POSTMASTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVERNMENT</b>	
11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Davis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hoskins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. Roy Tasco Davis</b>		Address <b>3802 Thornapple St. Chevy Chase, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Bronchial</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 4, 1957</b> to <b>April 12, 1961</b> , that (I) (we) lost the deceased alive on <b>April 11, 1961</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>W. B. WARDROP</b>		22b. DATE SIGNED <b>4/12/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. B. WARDROP</b>		22d. ADDRESS <b>800 Pershing Drive Silver Spring Md</b>	
23a. BURIAL, CREMATION, TRANS. & BURIAL <b>4/17/61</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>MENDSCINO CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>PARLETER, FRESNO COUNTY, CALIFORNIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumper, Inc. Raymond A. Ziska</b>		25a. REC'D BY REGISTRAR <b>APR 19 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

STATEMENT OF DEATH

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STATEMENT OF DEATH  
I, the undersigned, being a duly qualified medical practitioner, do hereby certify that on the 11th day of April, 1911, at the residence of the deceased, I attended the body of one John Davis, who died of a heart attack, and that he was found dead at his residence, and that he had been dead for some time before I was called to attend him.

John Davis  
April 11, 1911  
P. 2. 11

John Davis  
April 11, 1911  
P. 2. 11

John Davis  
April 11, 1911  
P. 2. 11

John Davis  
April 11, 1911  
P. 2. 11

John Davis  
April 11, 1911  
P. 2. 11

John Davis  
April 11, 1911  
P. 2. 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

4443

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04440

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3295 Arcadia Place, N. W.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Salvatore DELUCA				4. DATE OF DEATH Month Day Year April 30 19 61			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-19-1870	
9. AGE (In years last birthday) 90 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Sergeant		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		9. AGE (In years last birthday) 90 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Italy				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1897 to 1921 None			
17. INFORMANT (D) Mrs. Katherine E. Gass, 4500 S. Capital St.				Address Washington, D. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) arteriosclerotic heart disease (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 year years				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bethesda				20g. (County) Montgomery		20h. (State) Maryland	
21. I certify that (X) (this hospital) attended the deceased from April 29, 19 61 to April 30, 19 61 that (X) (we) last saw the deceased alive on April 30, 19 61 and that death occurred at 3:52 AM, from the causes and on the date stated above.							
22a. SIGNATURE Paul G. Linaweaver, LT, MC, USN				22b. DATE SIGNED 5-1-61			
22c. PHYSICIAN'S NAME (Type) Paul G. LINAEWEAVER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-4-61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Pennsylvania Ave, SE, WashDC	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR DATE MAY 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida b. COUNTY Key West	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 18 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS WLe Rest Beach	
3. NAME OF DECEASED (Type or print) First Middle Last Rebecca Anne DENNY		4. DATE OF DEATH Month Day Year April 18 1961	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-60
9. AGE (In years last birthday) yrs. 4		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY Arkansas	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carleton Edgar DENNY		14. MOTHER'S MAIDEN NAME Shirley Anne HUFFMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) C. E. Denny, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Congenital Heart Disease DUE TO (b) (Transposition of Great Vessels) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (X) (this hospital) attended the deceased from March 30, 1961, to April 18, 1961, that (N) (we) last saw the deceased alive on April 18, 1961, and that death occurred at 10AM, from the causes and on the date stated above. 22a. SIGNATURE C. W. BRAMLETT, LT, MC, USN 22b. DATE SIGNED 4-18-61 22c. PHYSICIAN'S NAME (Type) XXXXXX XXXXXXXXXX, COR, MC, USN 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 4-19-61	
23c. NAME OF CEMETERY OR CREMATORY Delight Cemetery		23d. LOCATION (City, town or county) (State) Delight Arkansas	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR APR 19 1961 25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04442

<b>1. PLACE OF DEATH</b> a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Punta Gorda			
f. STREET ADDRESS Princess Hotel		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John James DONOHUE		4. DATE OF DEATH April 7 1961		5. SEX Male	
6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-23-93	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) XXXXXX Pennsylvania USA	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		12b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank DONOHUE		14. MOTHER'S MAIDEN NAME Bridget MC KEEVER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI- WWII		16. SOCIAL SECURITY NO. 015-24-4865		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) carcinoma pancreas - metastatic INTERVAL BETWEEN ONSET AND DEATH 4 mo.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (he) (this hospital) attended the deceased from March 28, 1961 to April 7, 1961, that (s) (we) last saw the deceased alive on April 7, 1961, and that death occurred at 11AM, from the causes and on the date stated above.					
22a. SIGNATURE B. H. Rice		22b. DATE SIGNED 4-7-61		22c. PHYSICIAN'S NAME (Type) B. H. RICE, LT, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment			
23b. DATE THEREOF 11 APR 61		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City, town or county) (State) Delaware County, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		24b. ADDRESS R.A. Humphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE APR 11 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

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TO DEPUTY METROPOLITAN EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/S9

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>Md</i>		b. COUNTY <i>Montg</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berwood</i>		c. LENGTH OF STAY IN lb <i>6 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>		<i>07</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Newwood Rd.</i>				d. STREET ADDRESS <i>437 Gaither St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lucille Violet</i>		First <i>Lucille</i>		Middle <i>Violet</i>		Last <i>Dove</i>	
4. DATE OF DEATH <i>Apr 30 1961</i>		5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>8-15-23</i>		9. AGE (In years last birthday) <i>37</i> yrs.		IF UNDER 1 YEAR Months <i>30</i> Days <i>07</i>		IF UNDER 24 HRS. Hours <i>00</i> Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. PLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>	
13. FATHER'S NAME <i>Edward Lee Runyon</i>				14. MOTHER'S MAIDEN NAME <i>Hazel Reese</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>217-30-6916</i>		17. INFORMANT <i>Marion Dove</i>		Address <i>Illion 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Bhogsch</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. Bhogsch</i>				DATE SIGNED <i>4-30-61</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-3-61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>		22d. LOCATION (City, town, or country) (State) <i>Rockville, Md.</i>	
23. FUNERAL DIRECTOR <i>Francis H. Barber</i>				24a. REC'D BY REGISTRAR DATE <i>MAY 2 '61</i>			
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

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NAVY AND MARINE CORPS MEDICAL TRAINING CENTER  
DEPARTMENT OF THE NAVY  
WASHINGTON, D. C. 20340

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NAVY AND MARINE CORPS MEDICAL TRAINING CENTER  
DEPARTMENT OF THE NAVY  
WASHINGTON, D. C. 20340

NAVY AND MARINE CORPS MEDICAL TRAINING CENTER  
DEPARTMENT OF THE NAVY  
WASHINGTON, D. C. 20340

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

Item 18 Film 285 4-27-61 MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04444											
1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>					
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>						d. STREET ADDRESS <u>1257 E. Mont. Ave.</u>					
3. NAME OF DECEASED (Type or print) First <u>Zachariah</u> Middle <u>Alton</u> Last <u>Duvall</u>						4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/5/10</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Zachariah Zachariah T. Duvall</u>						14. MOTHER'S MAIDEN NAME <u>Marion Louisa Ward</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>214-03-9932</u>		17. INFORMANT <u>Howard L. Shores - 2704 Terrapin Rd., Sil. Spr.</u> Address <u>Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fat embolism</u>											
322.1 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic alcoholism</u>											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						22b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
22d. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-13-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>4-15-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Grove</u>		22d. LOCATION (City, town, or country) (State) <u>Woodfield, Md.</u>	
23. FUNERAL DIRECTOR <u>Francis H. Barber</u> Laytonsville, Md.						24a. REC'D BY REGISTRAR <u>DATE APR 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

259 E. North Ave.

01/2/85

21-00-0000 - Howard J. Shores - 2700 Vermont St., S.W., Wash., D.C.

• *collected*

4453

## CERTIFICATE OF DEATH

Reg. Dist. No.

04445

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLESVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANGLEY PARK</u>			
c. LENGTH OF STAY IN 1b <u>3 YRS.</u>				d. STREET ADDRESS <u>8204 NEW HAMPSHIRE AVE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marlow Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES L. EAKINS</u>				4. DATE OF DEATH Month Day Year <u>April 17 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 8, 1876</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARTICULAR NURSE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>		11. BIRTHPLACE (State or foreign country) <u>IOWA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>OTTO BURI</u>				14. MOTHER'S MAIDEN NAME <u>SARAH FITZPATRICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MARIE KNIGHT SISTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocardial Disease</u> DUE TO (c) <u>Thrombosed Coronary Arteries</u>							INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 13, 1958</u> , to <u>April 17, 1961</u> , that I last saw the deceased alive on <u>April 17, 1961</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>John S Rogers</u> M.D.				<u>1919 Peninsula Rd 4-17-61</u>			
PHYSICIAN'S NAME (Type) <u>JOHN S ROGERS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR 20, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTVIEW</u>		22d. LOCATION (City, town, or county) (State) <u>ATLANTA, GA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Taltrowell</u> ADDRESS <u>3603 14th St NW DC</u>				24a. REC'D BY REGISTRAR <u>DATE PR 19 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BIRTH [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		RELIGION [Faint text]	
MARITAL STATUS [Faint text]		PREVIOUS MARRIAGES [Faint text]		PREVIOUS DEATHS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	

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This certificate is to be filled out by the physician or other person authorized by the State Department of Health. It is to be filled out at the time of death, and is to be filed in the office of the State Department of Health. It is to be filled out in duplicate, and one copy is to be retained in the office of the State Department of Health, and the other copy is to be sent to the local health officer.





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Division of Columbia

Washington

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U. S. Naval Hospital, Bethesda, Md.

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# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. File pages 4 and 5 with the funeral director. Page 5 may be retained for your files.

VS. A15ME  
SM 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.O.A.</u>		c. LENGTH OF STAY IN 1b <u>18</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash San. &amp; Hosp</u>		d. STREET ADDRESS <u>17421 Carroll Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Glenn Elliott</u>		4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-15-95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		9. AGE (In years last birthday) <u>66</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maine</u>	
13. FATHER'S NAME <u>Charles Elliott</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		14. MOTHER'S MAIDEN NAME <u>Ada Clark</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Old Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brischant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BRISCHANT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S NAME (Type) <u>Funeral Home</u>		24a. REC'D BY REGISTRAR <u>5103 Wisconsin Ave. N.W. Wash. D.C.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		DATE <u>APR 10 '61</u>	

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MEDICAL CERTIFICATION

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OF NEW YORK

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

4456

04448

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery, Bethesda</u> — <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RESMOR Sanatank</u> c. LENGTH OF STAY IN 1b <u>57</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9 Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> h. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sumner</u> d. STREET ADDRESS <u>5709 Rockmere Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Miriam</u> First <u>Parthemer</u> Middle <u>Engle</u> Last			<b>4. DATE OF DEATH</b> <u>April 28</u> Month <u>1961</u> Day <u>1</u> Year				
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>4 July, 1885</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> <b>IF UNDER 24 HRS.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Pennsylvania</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>US</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>			<b>13. FATHER'S NAME</b> <u>E. Winfield Scott Parthemer</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>Early</u>			<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>				
<b>16. SOCIAL SECURITY NO.</b> <u>  </u>			<b>17. INFORMANT</b> <u>  </u> Address <u>  </u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 days</u> <u>years</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>  </u>							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct. 1958</u> <b>to</b> <u>4-28-61</u> <b>that (I) (we) last saw the deceased alive on</b> <u>4-28-61</u> <b>and that death occurred</b> <u>10:55 PM</u> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>C. P. Ryland</u>		<b>22b. DATE SIGNED</b> <u>4-28-61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>C. P. RYLAND</u>			
<b>22d. ADDRESS</b> <u>4400-49th ST. Wash 16 DC.</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>					
<b>23b. DATE THEREOF</b> <u>5/1/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>East Harrisburg Cemetery</u>		<b>23d. LOCATION (City, town, or county)</b> <u>Harrisburg, Penna.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>L. H. Hines Co.</u>		<b>ADDRESS</b> <u>2901-14th ST. N.W.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>		<b>DATE</b> <u>MAY 1 '61</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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# CERTIFICATE OF DEATH

04448

## MEDICAL CERTIFICATION

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 2 hours after

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MEADOWOOD</u>	
c. LENGTH OF STAY IN 1b <u>30 min</u>		d. STREET ADDRESS <u>33 Thomas Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Sen + Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alfred Lee Everhart</u>	4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1961</u>		
5. SEX <u>W</u>	6. COLOR OR RACE <u>M</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Donald S. Hay Construction Firm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS EVERHART</u>		14. MOTHER'S MAIDEN NAME <u>McCrossin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-03-0471</u>	
17. INFORMANT <u>Mrs. Eleanore M. Everhart, 23 Thomas Drive</u>		Address <u>Meadowood, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/8/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel M. P. Church Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Sunshine, Maryland</u>	
23. FUNERAL DIRECTOR <u>Raymond E. Pumphrey, Inc.</u>		24a. REC'D BY REGISTRAR <u>APR 11 '61</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Pumphrey</u>	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH  
30 min

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

DATE SIGNED  
4-5-61

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



NAME OF DECEASED  
RESIDENCE  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF EXAMINER  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04451

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 yrs. + time</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Balls Nursing Home 7420 Maple Ave.</u>		e. STREET ADDRESS <u>425 BUTTERNUT ST. N.W.</u>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MAY</u> Middle <u>FENTON</u> Last <u>FENTON</u>		<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>5</u> Year <u>1961</u>									
<b>5. SEX</b> <u>F.</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/12/1867</u>								
<b>9. AGE</b> (In years last birthday) <u>94</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Government clerk</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
	Hours										
	Min.										
<b>11. BIRTHPLACE</b> (State or foreign country) <u>District of Columbia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>									
<b>13. FATHER'S NAME</b> <u>William Fenton</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Cordelia Walker</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>Helet M. Donaldson</u>									
<b>17. INFORMANT</b> <u>Helet M. Donaldson</u>		Address <u>425 Butternut St. N.W. Wash. D.C.</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis with Cardiac Failure</u> DUE TO (b) <u>Nephro-sclerosis with Uremia</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Undetermined</u> <u>Undetermined</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>									
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that I attended the deceased from</b> <u>June 1, 1947</u> <b>to</b> <u>Apr 5, 1961</u> , <b>that I last saw the deceased alive on</b> <u>Apr 4, 1961</u> , <b>and that death occurred at</b> <u>232P</u> <b>M.</b> <b>from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) <u>10620 Sigma Ave</u> <b>DATE SIGNED</b> <u>Apr 5, 1961</u>											
<b>ACTUAL SIGNATURE</b> <u>George L Ball</u> M.D.		<b>PHYSICIAN'S NAME (Type)</b> <u>George L Ball Silver Spring Md</u>									
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>4-8-61</u>									
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Glennwood Cem</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Washington D.C.</u>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Real Funeral Home</u>		<b>ADDRESS</b> <u>4812 9th Ave NW</u>									
<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>APR 10 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4460

04452

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4510 Drummond Ave.</b>		d. STREET ADDRESS <b>4510 Drummond Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>ORLINE FENWICK</b>		4. DATE OF DEATH <b>April 14, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1883</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>77</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>New Orleans, La.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Ignatius J. Fenwick</b>		14. MOTHER'S MAIDEN NAME <b>Julia Duncan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Ruth S. Daly</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized atherosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>15 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 13, 1961</b> to <b>April 14, 1961</b> , that (I) <b>(was)</b> last saw the deceased alive on <b>April 13, 1961</b> and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John V. Dolan</b>		22b. DATE SIGNED <b>4-14-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN V. DOLAN</b>		22d. ADDRESS <b>3100 Conn. Ave., N.W., Washington, D. C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-17-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>
23d. LOCATION (City, town or county) <b>Washington, D. C.</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>		DATE <b>APR 19 '61</b>	



ALSO

ALSO

Montgomery

Montgomery

Shaw, Jacob

Shaw, Jacob

4310 Broadway Ave.

4310 Broadway Ave.

ORLINE

BENNETT

Kenzie, Miss

Kenzie, Miss

Hotchkiss

Hotchkiss

Lawrence J. Lawick

Julia Gordon

None

None

1008 East-West Highway  
Silver Spring, Md.

1

*Personal notes - Bureau*

JOHN V. BOLAN

2100 Conn. Ave., N.W., Washington, D.C.

Robert A. Burrey

Robert A. Burrey

4-17-61

4-17-61

Washington, D.C.

4-17-61

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>4461</div> </div> <div> <div>MONTGOMERY</div> <div>MARYLAND</div> </div> </div> <div> <div>4453</div> <div>04453</div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althea Woodland Nursing Home</u>				d. STREET ADDRESS <u>19131 Aldershot Dr</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Caroline Finney</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>16</u> Year <u>1961</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-1877</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Dusenbury</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>Nursing Home record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>9030</u> (b) <u>RIGHT COMMON ILIAC PHLEBOTHROMBOSIS, COMPLETE</u> DUE TO (c) <u>POSTOPERATIVE CONDITION FOLLOWING SURGERY FOR HIP FRACTURE</u>										INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Refused fall on floor at home</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3-21</u> 1961 p.m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
				20f. (City or town) <u>Bethesda</u>				20g. (County) <u>Montg</u>			
				20h. (State) <u>md.</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>4-16-61</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosehart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>April 17, 1961</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Crematory</u>			
				22d. LOCATION (City, town, or country) <u>Colmar Manor, Md.</u>							
23. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hauer</u>	

(M)

(I)

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15

2

2

06103

1181

(M)

(I)

1181

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1181

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MONTGOMERY STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04454											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>45 Bethesda</u> d. STREET ADDRESS <u>6403 Winnepeg Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>La Verne C Fisher</u>						4. DATE OF DEATH <u>April 20th, 1961</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 22-1929</u>		9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Hagberg</u>						14. MOTHER'S MAIDEN NAME <u>Verna (Unknown)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>Yes Unknown</u>		17. INFORMANT <u>Joseph J Fisher (Husband)</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Collegen-Vascular disease - type undetermined</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Myocarditis - type undetermined</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-20-61</u> Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/25/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>						24a. REC'D BY REGISTRAR <u>APR 25 '61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

VS. A15ME  
5M 7/59



I

Robert . . . . .  
Arlington Hall, Va.  
Arlington Hall, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4463

## CERTIFICATE OF DEATH

04455

<b>1. PLACE OF DEATH</b> a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) Christine Neal		4. DATE OF DEATH April 25 19 61		5. SEX Female	
6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-94	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (County & State, or foreign country) Illinois	
13. FATHER'S NAME John NEAL		14. MOTHER'S MAIDEN NAME Mary DAVIS		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (H) Clifford E. Fleming, 7505 Exeter Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic Stenosis 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Fever DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 10 yrs. Years Years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Arlington		20g. (County) Virginia		20h. (State) Virginia	
21. I certify that (H) (this hospital) attended the deceased from April 14 1961 to April 25 1961 that (H) (we) last saw the deceased alive on April 25 1961, and that death occurred at 8:05 AM, from the causes and on the date stated above.					
22a. SIGNATURE J. M. Young, Jr., MC, USN		22b. DATE 4-25-61		22c. PHYSICIAN'S NAME (Type) J. M. Young, Jr., MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-28-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) Arlington		23e. (State) Virginia		23f. (Country) USA	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		24b. ADDRESS Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE APR 28 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas		25c. REGISTRAR'S SIGNATURE Arthur L. Thomas			

(M)

(1)

R. A. Kennedy, General Home, Bethesda, Md.

1-10-61

Washington National

Allegation

Virginia

U. S. House, Md., USA

U. S. Naval Hospital, Bethesda, Md.

U. S. House, Md., USA

U. S. House, Md., USA

;

Psychiatric Hospital, Bethesda, Md.

Psychiatric Hospital, Bethesda, Md.

Psychiatric Hospital, Bethesda, Md.

Psychiatric Hospital, Bethesda, Md.

John A. A. A.

John A. A. A.

T. A. A. A.

T. A. A. A.

T. A. A. A.

U. S. House, Md., USA

U. S. House, Md., USA

U. S. House, Md., USA

U. S. House, Md., USA

U. S. House, Md., USA

U. S. House, Md., USA

U. S. House, Md., USA

U. S. House, Md., USA

U. S. House, Md., USA

U. S. House, Md., USA

U. S. House, Md., USA

U. S. House, Md., USA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4464

## CERTIFICATE OF DEATH

Reg. Dist. No. 04456

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4800 MORGAN DRIVE</u>		d. STREET ADDRESS <u>4800 Morgan Drive</u>	
3. NAME OF DECEASED (Type or print) <u>MARY CUETARA</u> First Middle Last		4. DATE OF DEATH <u>April</u> Month <u>29</u> Day <u>19</u> Year <u>61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1872</u> 9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>CLEARFIELD PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>JOSEPH CUETARA</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA Berger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>SISTER MRS Frances Murphy</u> Address <u>Ch. Ch. MD 4800 Morgan Dr</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>DIABETES MELLITUS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 WIC</u> <u>10 yrs</u> <u>13 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 15, 1958</u> , to <u>April 29, 1961</u> , that I last saw the deceased alive on <u>April 29, 1961</u> , and that death occurred at <u>8:15 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lewis H Biben</u> M.D.		ADDRESS (Street, city or town, state) <u>915 17th St NW</u> DATE SIGNED <u>4/29/61</u>	
PHYSICIAN'S NAME (Type) <u>LEWIS H BIBEN</u>		<u>Wash DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 5/4/61</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Clearfield, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 3 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Pines</u>

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text, possibly "John Doe"]</p>		<p>2. SEX                  [Faint text, possibly "Male"]</p>		<p>3. AGE                  [Faint text, possibly "45"]</p>		<p>4. DATE OF BIRTH                  [Faint text, possibly "10-15-1900"]</p>	
<p>5. PLACE OF BIRTH                  [Faint text, possibly "Baltimore, Md"]</p>		<p>6. OCCUPATION                  [Faint text, possibly "Teacher"]</p>		<p>7. CAUSE OF DEATH                  [Faint text, possibly "Heart Disease"]</p>		<p>8. MANNER OF DEATH                  [Faint text, possibly "Natural"]</p>	
<p>9. DATE OF DEATH                  [Faint text, possibly "11-1-1945"]</p>		<p>10. TIME OF DEATH                  [Faint text, possibly "10:00 AM"]</p>		<p>11. PLACE OF DEATH                  [Faint text, possibly "Home"]</p>		<p>12. SIGNATURE OF PHYSICIAN                  [Faint signature]</p>	
<p>13. SIGNATURE OF REGISTRAR                  [Faint signature]</p>		<p>14. SIGNATURE OF WITNESS                  [Faint signature]</p>		<p>15. SIGNATURE OF DECEASED                  [Faint signature]</p>		<p>16. SIGNATURE OF NEXT OF KIN                  [Faint signature]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4465

## CERTIFICATE OF DEATH

Reg. Dist. No.

04457

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b> c. LENGTH OF STAY IN 1b <b>311. Spg., Md.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Althea Woodland 1000 Daleview Dr.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D of C</b> b. COUNTY <b>47X-3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5441 Nebraska Ave. N.W.</b> d. STREET ADDRESS <b>Dr. Washington, D.C.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Georgina Gauntlett Francis</b> ( <b>GEORGINA</b> )		4. DATE OF DEATH Month Day Year <b>APRIL 26, 1961</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-18-68</b>
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>England</b>
12. CITIZEN OF WHAT COUNTRY? <b>England</b> ✓			
13. FATHER'S NAME <b>Charles Gauntlett</b>		14. MOTHER'S MAIDEN NAME <b>Georgina Bailey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MR. JOHN A. FRANCIS</b>		Address <b>Wash. D.C. 5441-NEBRASKA AVE. N.W.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis, acute, generalized</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Adenocarcinoma of rectum</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility with severe hypertrophic arthritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>2 yrs, 8 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 31, 1945 to April 26, 1961</b> that I last saw the deceased alive on <b>April 23, 1961</b> , and that death occurred at <b>2:10 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>3729 Morrison St. N.W. 4-26-61</b> <b>Washington 15, D.C.</b> <b>3729 Morrison St. N. W.</b>			
ACTUAL SIGNATURE <b>Thomas A. Wildman</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. T. A. Wildman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APR. 29/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas M. Hyson</b>		24a. REC'D BY REGISTRAR <b>1300 - N ST. N.W. WASH. D.C.</b> DATE <b>APR 28 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

M

1

STATE OF NEW YORK  
COUNTY OF ...  
IN SENATE,  
January 1, 1901.  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1899.  
ALBANY:  
J. B. LEECH, STATE PRINTER,  
1901.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4466

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04458

Item 2 Film 0246 5/3/61 iwk

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>CRESSENTIA</b> Last <b>GEIGER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-13-1869</b>
9. AGE (In years lost birthday) yrs. <b>91</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>H.W</b>	
11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Mesle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Heart Failure</b> <b>434.2 DUE TO</b> <b>Acute Pulmonary Edema</b> <b>Terminal Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1961</b> to <b>April 7, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 6, 1961</b> , and that death occurred at <b>12:10 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>L. I. Leal</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>L. I. LEAL, M. D.</b>		22d. ADDRESS <b>GAITHERSBURG, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-10-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Washington D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>APR 13 '61</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible] CAUSE OF DEATH: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

DECEASED WAS: [illegible] MARRIED: [illegible] OCCUPATION: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4467

CERTIFICATE OF DEATH

Reg. Dist. No. 04459

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b <u>5 1/2 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 17	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6612 Allegheny Ave</u>		d. STREET ADDRESS <u>6612 Allegheny Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Ellen Giddings</u>		4. DATE OF DEATH Month Day Year <u>April 21 1961</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-18, 1873</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ashton T. Coburn</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ann Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lottie C. Carter (Daughter) same as deceased.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1956</u> , to <u>April 21, 1961</u> , that I last saw the deceased alive on <u>April 14, 1961</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.		ADDRESS (Street, city or town, state) <u>2217 Carroll Ave</u> DATE SIGNED <u>4-21-61</u>	
PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>		<u>Takoma Park Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-24-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	22d. LOCATION (City, town, or county) (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnnie Wallace</u> ADDRESS <u>254 Carroll St.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

4468  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04460

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>3 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>08 GAITHERSBURG</b> d. STREET ADDRESS <b>1 600 ROSE ANN PLACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>LOUIE</b> Middle <b>CHARLTON</b> Last <b>GILLIAM</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>19 61</b>						
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/31/84</b>	9. AGE (In years lost birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>77</b>	IF UNDER 24 HRS. Days <b>77</b>	Hours <b>77</b>	Min. <b>77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>-----</b>		14. MOTHER'S MAIDEN NAME <b>-----</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-10-5864</b>		17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Massive Myocardial Infarction</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>April 4, 1961</b> to <b>April 7, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 4, 1961</b> , and that death occurred at <b>10:55 P.M.</b> from the causes and on the date stated above.								
22a. SIGNATURE <b>Louie L. Leal</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <b>L. I. LEAL, M. D.</b>		22d. ADDRESS <b>GAITHERSBURG, MARYLAND</b>		22b. DATE SIGNED <b>4/7/61</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-9-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		23d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>		

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04461

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>9 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>6001 Berkshire Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Louise Whipp</b> First Middle Last 4. DATE OF DEATH <b>April 18 1961</b> Month Day Year				5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>12/30/86</b> 9. AGE (In years last birthday) <b>74</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b> 11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>Benjamin Franklin Whipp</b> 14. MOTHER'S MAIDEN NAME <b>Gertrude Swickard</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>8001 Berkshire Drive Bethesda, Maryland</b> 17. INFORMANT <b>Mrs. Betty Meeds</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> 331X DUE TO (b) <b>Cerebrovascular degeneration</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>April 18, 1961</b> to <b>April 18, 1961</b> that (I) (we) last saw the deceased alive on <b>April 18, 1961</b> , and that death occurred at <b>AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>George A. Gray, Jr.</b> M.D. 22b. DATE SIGNED <b>April 18, 1961</b> 22c. PHYSICIAN'S NAME (Type or print) <b>George A. GRAY, JR.</b> 22d. ADDRESS <b>4740 Chevy Chase Dr Chevy Chase, Md.</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b> 23b. DATE THEREOF <b>4/18/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b> 23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Blaschke Funeral Home</b> ADDRESS <b>4739 Bell St. Hyattsville, Md.</b> 25a. REC'D BY REGISTRAR <b>APR 21 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Surgical Hospital" and "Surgical" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Items 14 & 23b, Film G-285 4/24/61.cac.

04462

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>St. Petersburg 13</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>99 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>2530 1/2 Burlington Ave.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louis Ellis GROOT</b>				4. DATE OF DEATH Month Day Year <b>April 14 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-22-87</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William GROOT</b>		14. MOTHER'S MAIDEN NAME <b>Mary STUBAS STUBAUS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>WWI &amp; WWII</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Congestion</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Metastatic Carcinoma</b> DUE TO (c) <b>Transitional cell carcinoma, Urinary Bladder</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (x) (this hospital) attended the deceased from <b>Jan. 5 1961</b> to <b>April 14 1961</b> that (x) (we) last saw the deceased alive on <b>April 14 1961</b> , and that death occurred at <b>5A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Jack D. Real</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4-14-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jack D. REAL, LT, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-19-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey Funeral Home</b>				25a. REC'D BY REGISTRAR <b>APR 18 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4471  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04463

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Congressional Manor Sanitarium</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>438 Emerson St. N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Susan Ida Hamilton</b>		4. DATE OF DEATH Month <b>Apr.</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-5-1873</b>
9. AGE (In years last birthday) <b>87</b>		10. IF UNDER 1 YEAR Months <b>87</b> Days <b>87</b> Hours <b>87</b> Min. <b>87</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Heflin</b>		14. MOTHER'S MAIDEN NAME <b>Susan Holder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Fred J. Miller-Neice-Roth</b>		Address <b>Green Acres</b> <b>Rd. Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral vascular accident</b> DUE TO <b>5 yrs</b> (c) <b>Generalized arteriosclerosis</b> DUE TO <b>? years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 17, 1958</b> to <b>April 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 2, 1961</b> , and that death occurred at <b>1030 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>E. Bowditch Hunter, Jr.</b> M.D.		22b. DATE <b>Apr. 3, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. Bowditch Hunter, Jr., MD</b>		22d. ADDRESS <b>809 Veins Mill Rd., Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/6/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR DATE <b>APR 6 '61</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
4472  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04464

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>8 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>St. Petersburg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4 8X-2</b> d. STREET ADDRESS <b>5155-15th Street, North</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Linda</b> Middle <b>Lou</b> Last <b>Hammett</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1948</b>
9. AGE (In years last birthday) <b>12</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min. <b>12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Alaska</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Hammett</b>		14. MOTHER'S MAIDEN NAME <b>Marie Ditrich</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>National Institutes of Health, Bethesda 14, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Cardiac Failure, Respiratory Failure</b> <b>&gt; 54.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Tetralogy of Fallot, Postoperative State</b> DUE TO (c) <b>Birth</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 18, 19 61</b> to <b>April 26, 19 61</b> that (I) (we) last saw the deceased alive on <b>April 26, 19 61</b> and that death occurred at <b>8:05a</b> AM, from the causes and on the date stated above.		22a. SIGNATURE <b>E. Kent Carney</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>4-26-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. KENT CARNEY, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		23b. DATE THEREOF <b>4/27/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		23d. LOCATION (City, town, or county) (State) <b>St. Petersburg, Florida</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 2 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

1  
M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
4473 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04465													
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>10404 Montgomery Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Lawrence Aloysius Hanley</b>						4. DATE OF DEATH Month Day Year <b>April 22, 1960 19</b>		9. AGE (In years last birthday) <b>66</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 6, 1894</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Life Ins. Broker</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>private</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>					
13. FATHER'S NAME <b>Cornelius Hanley</b>						14. MOTHER'S MAIDEN NAME <b>Downs</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 1917-19; 1942-44</b>						16. SOCIAL SECURITY NO. <b>455-03-0795</b>						17. INFORMANT <b>Mrs Mary Hanley, as above -wife</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420-1</b> <b>Coronary occlusion</b> DUE TO (b) <b>sudden</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of hypertension + previous heart disease</b>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Franz J. Blusch</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <b>FRANK J. Blusch</b>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>4-22-61</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/26/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>							
23. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>						ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 25 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



(I)

Yes 1917-19; 1918-19

Left Mary Hanley, as above

Conneline Hanley

John Jones

Life Ins. Broker

private

Indiana

U.S.

M

x

May 6, 1921

66

Insurance Agency Hanley

April 22, 1920

Edward

Edward

10101 Montgomery Ave.

x

Patricia

D.C.A.

Kenneth

Montgomery

Maryland

Montgomery

Robert A. Humphrey, Bethesda, Maryland, 1921

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4474

04466

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN lb <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1809 Piney Branch Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>Henry</u> Middle <u>Hannan</u> Last <u>Hannan</u>		4. DATE OF DEATH <u>April 27</u> Month <u>April</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-71</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FIRE INS RATING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUREAU</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>STEARLING, ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>Luke HANNAN</u>		14. MOTHER'S MAIDEN NAME <u>MARY BROWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>8009 PINEY BR RD</u>	
17. INFORMANT <u>BERNICE E MCDANIEL</u>		Address <u>8009 PINEY BR RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic leukemia</u> 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>December, 1960</u> , to <u>April 27, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 18, 1961</u> , and that death occurred at <u>530</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>		22b. DATE SIGNED <u>April 27, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		22d. ADDRESS <u>9301 Colesville Rd, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>4-29-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Stutland Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u>		ADDRESS <u>4812 Gt. Ave NW</u>	
25a. REC'D BY REGISTRAR <u>MAY 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

03800

03800

①

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Lumber" and "Board" are faintly visible.]*

## CERTIFICATE OF DEATH

Reg. Dist. No. 04467

4475

M

## 1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

SILVER SPRING

c. LENGTH OF STAY IN 1b

4 YRS

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

14 SILVER SPRING

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

MARILLA NURSING HOME

d. STREET ADDRESS

COLESVILLE RD

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

BESSIE

Middle

F.

Last

HAVENER

4. DATE OF DEATH

Month

Day

Year

April 20

19 61

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

2-24-76

9. AGE (In years last birthday)

85 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

NO

16. SOCIAL SECURITY NO. (If yes, give year or dates of service)

NONE

INFORMANT

Address

4372 KNOWLES ST

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

331X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

72 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

None

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.

20d. INJURY OCCURRED While ☐ Not while ☐ at work ☐ of work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from May 14, 1959, to April 20, 1961, that I last saw the deceased alive on April 8, 1961, and that death occurred at 114 M, from the causes and on the date stated above.

ACTUAL SIGNATURE

John D. Rogers

M.D.

ADDRESS (Street, city or town, state)

1919 Seminary Rd

DATE SIGNED

4-20-61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

4-22-61

22c. NAME OF CEMETERY OR CREMATORY

UNION CEMETERY

22d. LOCATION (City, town, or county)

LEESBURG, VA.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

W.W. Chambers Co. 1400 Chapin St NW

24a. REC'D BY REGISTRAR

DATE APR 24 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Evans

CERTIFICATE OF DEATH

1917

(M)

Blank certificate form with horizontal lines for text entry.

(I)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4476

## CERTIFICATE OF DEATH

04468

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>11826 Rocking Horse Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Elizabeth Hawes</u>		4. DATE OF DEATH Month Day Year <u>April 27 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>1</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul T. Hawes</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Bradley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Parents - same as above</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypoxia</u> 760.0 DUE TO (b) <u>Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Increased intracranial pressure 6 mos.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Congenital Absence of 10th of 10th</u> <u>Hydrocephalus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>24 hours</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Reg. 28.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Birth</u> , 19 <u>10:25 P.M.</u> , to <u>Apr 27</u> , 1961, that (I) (we) last saw the deceased alive on <u>Apr 27</u> , 19 <u>61</u> , and that death occurred at <u>10:25 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John T. Lord M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John T. Lord M.D.</u>		22d. ADDRESS <u>1015 Spring St. Silver Sp</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5-1-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Wheaton Md</u>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hanlon</u> ADDRESS <u>3831 Heavens</u>		25. REC'D BY REGISTRAR <u>DATE MAY 5 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur J. [Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/60

9VVVVVVVVVV

✓ 68140

RECEIVED

6743

W

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

04469

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>13 da.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3316 Runnymede Pl. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Sarah Annie Hayes</u>				<b>4. DATE OF DEATH</b> <u>April 20 1961</u>			
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>EW</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1-13-73</u>	
<b>9. AGE</b> (In years last birthday) <u>88</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u>			
<b>13. FATHER'S NAME</b> <u>Carson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war and dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>none</u>			
<b>17. INFORMANT</b> <u>Madelaine Hony</u> Address <u>Same as above</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO (b) <u>influenza</u> DUE TO (c) <u>Senility + A.S.H.D.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>480X</u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u>4/20</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/20</u> <b>to</b> <u>4/20</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>4/20</u> <b>and that death occurred at</b> <u>533</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Marvin Wadler</u> M.D.				<b>22b. DATE SIGNED</b> <u>4/20/61</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>MARVIN WADLER</u>				<b>22d. ADDRESS</b> <u>8218 Wis. Ave. Beth.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4/24/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Prince Georges Co. Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S. H. Hines Co. Washington, D. C.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>APR 24 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles L. Hines</u>	

VR A15 (4)  
15M 9/60

(M)

(I)

Wagon

Carriage

Stables

Room

F. W.

Wagon

Carriage

Room

Room

1840

Washington

330 Pennsylvania Ave

April 20 1861

1-13-73 88

Wagon

Carriage

Wagon

Washington

The S. H. Allen Co. Washington, D. C. 1873  
Remedy for the Sore Throat  
Bristol, N. H. 1871  
F. H. Allen

4478  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04470

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>				c. LENGTH OF STAY IN 1b <b>2 WEEKS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS SANITARIUM</b>				d. STREET ADDRESS <b>311 WATERFORD ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>VERONICA</b> Middle <b>M.</b> Last <b>HAYES</b>				4. DATE OF DEATH Month <b>4</b> Day <b>27</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-25-04</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK TYPIST</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>PATRICK J. MURPHY</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE CAHALIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>062-14-4531</b>		17. INFORMANT <b>Mrs. J. Leo Meyer</b> Address <b>311 Waterford Road, Kensington, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix with metastases</b> DUE TO (b) <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1961</b> to <b>April 1961</b> , that (I) (we) last saw the deceased alive on <b>4-24-61</b> , and that death occurred at <b>10:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Bernard A. Dygner</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Francis Collins</b>	
22d. ADDRESS <b>217 University Dist E. S.D., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-1-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Collins</b> ADDRESS <b>3821-14th St. N.W. Wash. D.C.</b>				25. REC'D BY REGISTRAR <b>Charles L. Haines</b>		25b. REGISTRAR'S SIGNATURE	
DATE <b>MAY 1 '61</b>							

STATE OF MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

11-12-11

1911



Now deceased  
Name of deceased  
Age at death  
Sex  
Date of death  
Place of death  
Cause of death  
Signature of Registrar

Attest my hand and the seal of the Department of Health  
this 12th day of November 1911  
Registrar

1  
 M  
 090  
 4479  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 04471

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>21 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanatorium</u>				d. STREET ADDRESS <u>4513 Harrison St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ellen R HEARD</u>				4. DATE OF DEATH Month Day Year <u>April 28 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-1893</u>	9. AGE (In years last birthday) <u>68</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A. - DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ALEXANDER A. POURET</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth DOLEMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs Lucie E Raymond 4513 Harrison St N.W. Wash. DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSEPTIC CARDIOVASCULAR DISEASE</u> <u>422.01</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>Sept APR 4 1961</u> to <u>APRIL 28, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 24 1961</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Sarah E. Glover</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>April 28 1961</u> 22c. PHYSICIAN'S NAME (Type) <u>SARAH E. GLOVER.</u> 22d. ADDRESS <u>10128 CEDAR LANE Kensington, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Switzland Twp Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Cherry Chase Funeral Home Washington DC</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	

CERTIFICATE OF DEATH

1075

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4480

04472

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4, KENSINGTON</u> d. STREET ADDRESS <u>13922 DUNNELL LANE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>CHARLES HOFFMANN HELMS</u>				<b>4. DATE OF DEATH</b> <u>APRIL 1 1961</u>															
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>11/10/91</u>													
<b>9. AGE</b> (In years last birthday) <u>69</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>7</u></td> <td><u>27</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>7</u>	<u>27</u>			<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED (U.S. GOV'T.)</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>ASS'T. DEPUTY DIR. NACA (35 YRS.)</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>BROOKLYN, N. Y.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.																	
Months	Days	Hours	Min.																
<u>7</u>	<u>27</u>																		
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>GEORGE HELMS</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>LOUISE HOFFMANN</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>Yes-Unknown</u>													
<b>17. INFORMANT</b> <u>MRS. BELLE K. HELMS (WIFE)</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCT.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis, coronary Arteries</u> (c) <u>Peptic ulcer, duodenal healing</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>													
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>													
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb 28, 1961</u> <b>to</b> <u>Apr 1, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>April 1, 1961</u> , <b>and that death occurred at</b> <u>7:30 P.M.</u> <b>from the causes and on the date stated above.</b>																			
<b>22a. SIGNATURE</b> <u>Robert G. Tayler</u>				<b>22b. DATE SIGNED</b> <u>Apr 2, 1961</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Robert G. Tayler</u>													
<b>22d. ADDRESS</b> <u>Washington Clinic, Washington D.C.</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u>		<b>23b. DATE THEREOF</b> <u>4/4/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Crematory</u>													
<b>23d. LOCATION (City, town or county)</b> <u>Suitland, Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>		<b>ADDRESS</b> <u>Bethesda, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE APR 5 '61</u>													
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>																			



*Handwritten signature*

Resident

Robert A. Taylor

Robert A. Humphrey  
Bethesda, Maryland

Cedar Hill Crematory  
Bethesda, Maryland

Robert A. Taylor  
Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4481

## CERTIFICATE OF DEATH

04473

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN b. <b>Since June 1960</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8207 GRUBB ROAD, Apt. 104</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>8207 GRUBB ROAD, Apt. 104</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>KUMPEL</b> Last <b>HERBERT</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>19</b> Year <b>19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/7/10</b>
9. AGE (In years last birthday) <b>51 yrs.</b>		IF UNDER 1 YEAR Months <b>51</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Switchboard Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Suburban Hospital</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDGAR CARROW</b>		14. MOTHER'S MAIDEN NAME <b>NELLIE BURTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>221-10-6167</b>	
17. INFORMANT <b>Mrs. Robert Hanna</b>		Address <b>2533 Ross Road Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral anoxia</b> 331X DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hypertension</b> DUE TO <b>Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1961</b> to <b>April 1961</b> , that (I) (we) last saw the deceased alive on <b>4/18/1961</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Sanford J. Randall</b> M.D.		22b. DATE SIGNED <b>4/19/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>SANFORD J. RANDALL</b>		22d. ADDRESS <b>8329 Grubb Rd. S.S. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		23b. DATE THEREOF <b>4/19/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HICKORY GROVE CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>ST. GEORGES, DELAWARE</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>		25a. REC'D BY REGISTRAR <b>APR 21 '61</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 4482 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

ITEM #22 Film G286

5/8/61 1wk

05792

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>12 Rockville</u>		
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			d. STREET ADDRESS <u>1 Fields Road</u>		
d. NAME OF SUBURBAN OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Clarence Robert Howard</u>			4. DATE OF DEATH <u>Apr 30 1961</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-32</u>		9. AGE (In years last birthday) <u>29</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>Clarence H. Howard</u>			14. MOTHER'S MAIDEN NAME <u>Virgie Rickitta</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>			16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u></u> Address <u></u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transsection of spinal cord</u> DUE TO (b) <u>Multiple skull fractures</u> DUE TO (c) <u>Struck by car</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Sudden</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian - crossing highway &amp; struck by auto</u>		
20c. TIME OF INJURY Month, Day, Year <u>11:30 a.m. 4-29-61</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U.S. Route 240</u>			20f. (City or town) <u>Rockville</u> (County) <u>Montg</u> (State) <u>md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-30-61</u>		
			Address (Street, city, town, or county) <u></u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 2, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Neelsville Cemetery</u>	
				22d. LOCATION (City, town, or country) (State) <u>Neelsville, Mont. Co. Md.</u>	
23. FUNERAL DIRECTOR <u>Tyson Wheeler Fun. Home, 1331 E. Montgomery Rd., Rockville, Md.</u>			24a. REC'D BY REGISTRAR <u>MAY 2 '61</u>		
			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>		

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04474

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN lb <u>13 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg (rural)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R 70 # 3</u>				d. STREET ADDRESS <u>1 R 70 # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virgil Summer Hughes</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-10-94</u>	
9. AGE (in years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>meth.</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Singleton Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Bird</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Bertha Hughes (wife)</u> Address <u>Stm 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>4-1-61</u>			
Address (Street, city, town, or county) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/4/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn.</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert R. Swindle</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	

05450



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

4484  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04475

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>			
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Germantown</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Water Rd</u>				d. STREET ADDRESS <u>Water Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rachael</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-22-1904</u>	
9. AGE (In years last birthday) <u>57 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>Walter Smith</u>				14. MOTHER'S MAIDEN NAME <u>Ediz. Ring</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Robt Lee Hunt</u>				Address <u>Stone 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO (b) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Biosch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BIOSCH</u>				M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/26/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	
22d. LOCATION (City, town, or country) (State) <u>Beallsville MD</u>				23. FUNERAL DIRECTOR <u>William C. Hillen, Beallsville MD</u>			
24a. REC'D BY REGISTRAR DATE <u>APR 28 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE  
OF MASSACHUSETTS

(M)

April

1901

(I)

*[Faint, mostly illegible handwritten text, likely a signature or address, spanning the bottom half of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4485

CERTIFICATE OF DEATH

Reg. Dist. No.

04476

1. PLACE OF DEATH a. COUNTY <u>MONTG.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SSIG.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING. 26</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARILEA NURSING HOME</u>		d. STREET ADDRESS <u>11852 HUGGINS DR 1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLAIRE</u> Middle <u>-</u> Last <u>ISKOWITZ</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/1901</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y. CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK STEGMAN (Dec.)</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE HERSHBERG (Dec.)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ROBERT H. ISKOWITZ</u>		Address <u>11852 Huggins Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast with</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>widely spread metastases</u> DUE TO (c) <u>1 yr.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 13, 1961</u> , to <u>April 10, 1961</u> , that I last saw the deceased alive on <u>April 13, 1961</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. Rogers, M.D.</u>		DATE SIGNED <u>1961 Semiway Rd. Silver Spring, Md. 4-10-61</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>		ADDRESS <u>4217-9-Kue</u>	
24a. REC'D BY REGISTRAR <u>APR 12 61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

7

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 4486  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 04477

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>2+ yrs</u>				d. STREET ADDRESS <u>6700 Penny Branch Road NW</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seton Hospital, 1000 Lakeside Dr.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>ORCHARD</u> Last <u>ISRAEL</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-22-1872</u>	
9. AGE (In years lost birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Nashville, Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>John Orchard</u>				14. MOTHER'S MAIDEN NAME <u>Sarah McIlwain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mr. Winifred L. Coleman (Same as #2)</u> Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 wk</u> <u>Many years.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>61</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (1) (this hospital) attended the deceased from <u>July 12</u> 19 <u>58</u> , to <u>4/26</u> 19 <u>61</u> , that (2) (we) last saw the deceased alive on <u>7/26</u> 19 <u>61</u> , and that death occurred at <u>2:10</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>James R. Coleman MD.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>4/27/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>				22d. ADDRESS <u>733 Aligo Ave. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 29, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walton, 254 Carroll St NW DC</u> ADDRESS <u>  </u>				25a. REC'D BY REGISTRAR <u>  </u> DATE <u>MAY 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

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0117

EXHIBIT OF DEATH

1128

CHIEF OF POLICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4487

## CERTIFICATE OF DEATH

04478

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Le. Deau Gardens Nursing Home</u>		d. STREET ADDRESS <u>10419 HUNTLEY AVENUE</u>	
3. NAME OF DECEASED (Type or print) <u>Myrtle B. Jerman</u>		4. DATE OF DEATH <u>April 9th</u> 19 <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29th 1892</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Sebastian</u>		14. MOTHER'S MAIDEN NAME <u>MARY Adamson</u> [EMMA]	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Laird Jerman</u> (10419 Huntley Ave Silver Sp. Md.)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLISM → LEFT HEMIPLEGIA</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>AVRICULAR FIBRILLATION</u> (c) <u>CORONARY ATHEROSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 WEEKS</u> <u>3-4 YRS</u> <u>SEVERAL YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 22, 1960</u> , to <u>APRIL 9, 1961</u> , that I last saw the deceased alive on <u>APRIL 9, 1961</u> , and that death occurred at <u>11:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Roberts</u> M.D. <u>8907 Georgia Ave.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>APRIL 9, 1961</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		<u>SILVER SPRING, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>		22b. DATE THEREOF <u>4-13-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Switband Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas B. Handon</u>		ADDRESS <u>3831-GA. Ave N.W.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained to hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4488

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04479

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>22 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MABEL</b> Middle <b>LAVINIA</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/31/1900</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>SAMUEL T. HILL</b>		14. MOTHER'S MAIDEN NAME <b>MARY E. KING</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus,</b> DUE TO <b>Thrombosis, of Arterio</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Peptic ulcer duodenum.</b> Circulation of Liver INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b> <b>y + s</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/26</b> to <b>4/26</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>4/26</b> 19 <b>61</b> , and that death occurred at <b>6:00</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Ligon</b> M.D.		22b. DATE SIGNED <b>4/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES H. LIGON, M.D.</b>		22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/29/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sandy Spring,</b>		23d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b> ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 2 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Frank</b>			

1928

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

MARRIAGE

CHILDREN

PROPERTY

DECEASED'S SIGNATURE

WITNESSES

DECEASED'S ADDRESS

DECEASED'S PHONE

DECEASED'S SIGNATURE

WITNESSES

DECEASED'S ADDRESS

DECEASED'S PHONE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN b <b>3 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>FLORIDA</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ORLANDO</b> d. STREET ADDRESS <b>318 W. HAZEL AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROSE W. KARR</b>		4. DATE OF DEATH <b>April 13 1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/13/70</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months Days 13 1961	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. BIRTHPLACE (County & State, or foreign country) <b>SILVER SPRING, MD.</b>	
13. FATHER'S NAME <b>JOHN C. WILSON</b>		14. MOTHER'S MAIDEN NAME <b>SELINA PENDLETON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. Lawrence Z. Wilson</b>		Address <b>10, 102 Gates Ave. Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>CARCINOMA BLADDER</b> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 Mo.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/15</b> to <b>4/12</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/11</b> , 19 <b>61</b> , and that death occurred at <b>12:30</b> PM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry W. Stout MD.</b>		22b. DATE SIGNED <b>4/13/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>H.W. STOUT MD</b>		22d. ADDRESS <b>10011 GEORGIA AVE SILVER SPRING, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/15/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GRACE EPISCOPAL CHURCH CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		25. REC'D BY REGISTRAR <b>APR 19 '61</b>	
25a. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25b. REGISTRAR'S SIGNATURE	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04481

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>11707 Idlewood Road</b>			
3. NAME OF DECEASED (Type or print) <b>William Anthony Kastellos</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1961</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 24, 1900</b>	9. AGE in years (last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Athens Greece</b>			
13. FATHER'S NAME <b>Thomas Gust Kastellos</b>		14. MOTHER'S MAIDEN NAME <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U-S-A</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Washington San &amp; Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b> sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Bruschant</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BRUSCHANT</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4-4-61</b>			
22a. BURIAL, CREMATION, or other (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-7-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEM.</b>			
22d. LOCATION (City, town, or country) <b>SUITLAND MD.</b>		24a. REC'D BY REGISTRAR <b>4812 20th AVE</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			
23. FUNERAL DIRECTOR <b>DEAL FUNERAL HOME</b>		ADDRESS <b>WASH. D.C.</b>		DATE <b>APR 10 '61</b>			



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04482

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7009 Maple Ave</u>		d. STREET ADDRESS <u>7009 Maple Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Earl Foster Kelley</u>		4. DATE OF DEATH <u>Apr 22 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-29-86</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov. employee (retired) Pub. Roads</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Iowa</u>	
13. FATHER'S NAME <u>Thomas Kelley</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown) Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert Kelley-son-same 2d</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-22-61</u> ACTUAL SIGNATURE <u>Frank J. Broschait</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschait</u> Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 22b. DATE THEREOF <u>4/24/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> 22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u> 23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> 24a. REC'D BY REGISTRAR <u>APR 25 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH  
Found dead on bed room floor at home



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bluesy</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u> d. STREET ADDRESS <u>1 Batson Rd</u> e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thelma Juanita Kelly</u> First Middle Last 4. DATE OF DEATH <u>Apr 12 1961</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Col</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>2-20-61</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>1</u> <u>20</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (State or foreign country) <u>md</u> 12. CITIZEN OF WHAT COUNTRY? <u>md</u>		13. FATHER'S NAME <u>Norman Edw. Kelly Jr</u> 14. MOTHER'S MAIDEN NAME <u>Maryann Watkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Norman E. Kelly Jr (father)</u> Address <u>Stue 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>upper Respiratory Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>Long apparently dead</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>None</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u> 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Hans J. Broschert</u> EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-12-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>4/15/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Round Oak.</u> 22d. LOCATION (City, town, or country) (State) <u>Spencerville, Md</u>		23. FUNERAL DIRECTOR <u>Robert L. Suowder</u> ADDRESS <u>Rockville, Md.</u> 24a. REC'D BY REGISTRAR <u>APR 20 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

12073224XV6

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

(T)

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

4493

04484

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barnesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barnesville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Kincheloe</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/28/1873</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Nursing Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Adams Co., Illinois</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Michael</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
INFORMANT <b>Florence L. Atkinson-Barnesville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X Bronchial Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Renal Arteriosclerotic Disease with Uremia</b> DUE TO (c) <b>Arteriosclerotic Hypertensive Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>7 days</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rt. Hemiparesis due to old C.V.A.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 1958</b> to <b>25 April 1961</b> , that I last saw the deceased alive on <b>24 April 1961</b> , and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gordon M. Smith</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Barnesville 25 April 61</b>	
PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>		<b>Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4/28/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. 2901 14th St., N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 27 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

1

TO HOSPITAL OR AT HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1933

(M)

and for the purpose of the law, the death of the deceased is hereby certified to have taken place on the day and at the place hereinafter stated.

DECEASED  
Name of deceased  
Age  
Sex  
Color

Place of birth  
Date of birth

Occupation  
Cause of death

Signature of physician or other qualified person  
Signature of registrar

Signature of informant  
Date of death

Place of death  
Signature of registrar

Signature of informant  
Date of death

Place of death  
Signature of registrar

Signature of informant  
Date of death

Place of death  
Signature of registrar

Signature of informant  
Date of death

Place of death  
Signature of registrar

Signature of informant  
Date of death

Place of death  
Signature of registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)  
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

4494

04485

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Washington, DC.</i> b. COUNTY <i>DC.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b <i>11 Mos.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>4210-38th ST.</i>		d. STREET ADDRESS <i>47X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Sanatorium</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>MAY</i> Last <i>King</i>		4. DATE OF DEATH Month <i>April</i> Day <i>22</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>22 APRIL 1875</i>
9. AGE (In years lost birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Gregory Chanes</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Normile</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Hypertensive Cardiovascular Disease</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5-5</i> 19 <i>60</i> to <i>4-22</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>4-22</i> 19 <i>61</i> , and that death occurred at <i>3 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>James W. Egan</i>		22b. DATE SIGNED <i>4-22-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES W. EGAN</i>		22d. ADDRESS <i>7720 Wisconsin Ave. Bethesda Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>April 24, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Washington DC</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>H. Don DeVol</i>		25a. REC'D BY REGISTRAR DATE <i>APR 25 '61</i>	
ADDRESS <i>2224-Wis. Ave. N.W. DC</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

UNITED STATES OF AMERICA

(M)

(1)

1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4495

CERTIFICATE OF DEATH

Reg. Dist. No.

04486

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>75 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>10,400 Colesville Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>10,400 Colesville Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANGELA ELIZABETH KINSMAN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1874</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife—own home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Oliver Dorrance Kinsman</b>		14. MOTHER'S MAIDEN NAME <b>Emma Matilda Louisa Richardson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Olive D. Kinsman 10400 Colesville Rd. SS, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular thrombosis</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>cardio-vasc. disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>30 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1952</b> , 19____, to <b>22 April</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>22 April</b> , 19 <b>61</b> , and that death occurred at <b>8 P.</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Ernest E. Harmon</b> M.D. ADDRESS (Street, city, or town, state) <b>7301 Belcoville Rd Silver Spring, Md.</b> DATE SIGNED PHYSICIAN'S NAME (Type) <b>ERNEST E. HARMON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>April 25, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Montg. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>APR 25 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kins</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4496 CERTIFICATE OF DEATH 04487											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Poolesville Rural</b>						c. LENGTH OF STAY IN b. <b>5 Mo.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Matthews Nursing Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Mary Emma Klingensmith</b>						4. DATE OF DEATH <b>4 17 1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 18-1873</b>		9. AGE (In years last birthday) <b>87 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>206-01-6495D</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Levi Enfield</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						17. INFORMANT <b>John Klingensmith, 6800-Bradgrove Circle</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b> <b>6 months</b> <b>6 years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Bethesda, Maryland</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>22 Aug 1960</b> to <b>17 April 1961</b> , that (I) (we) last saw the deceased alive on <b>16 April 1961</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Gordon M. Smith</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>17 Apr 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>						22d. ADDRESS <b>Barnesville, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/19/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greensburg, Pa</b>				23d. LOCATION (City, town or county) (State)			
24 FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hill</b>						ADDRESS <b>Barnesville, Md</b>		25a. REC'D BY REGISTRAR <b>DATE APR 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

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Montgomery

Maryland

Montgomery

Poolsville Rural

3 Mo.

Bethesda

Madison Nursing Home

6800-Bradgrove Circle

x

Mary

Emma

Kingenham

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17

01

Female White

X

Sept 18-1873

87

Housewife

Pennsylvania

U.S.

Levi Enfield

Unknown

John Kingham, 6800-Bradgrove Circle  
Bethesda, Maryland

Gordon H. Smith

Barnesville, Md

Burial

1873

Greensburg, Pa

Barnesville, Md

Greensburg, Pa

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4497

CERTIFICATE OF DEATH

Reg. Dist. No. 04488

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>3 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>509 GILMORE DRIVE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>VESTA</b> Middle <b>L.</b> Last <b>KNODE</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/7/92</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>OTTO G. KRETZER</b>				14. MOTHER'S MAIDEN NAME <b>unknown JONES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT Address <b>Mrs. Miles Murphy, 509 Gilmore Drive Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Congestive failure of heart</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b>vascular disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>3-4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 10, 1961</b> to <b>April 26, 1961</b> that I last saw the deceased alive on <b>26 April, 1961</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9301 Colesville Rd. Silver Spring, Md.</b> DATE SIGNED <b>Ernest E. Harmon</b>							
ACTUAL SIGNATURE <b>Ernest E. Harmon</b>				PHYSICIAN'S NAME (Type) <b>ERNEST E. HARMON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/29/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SHEPARDSTOWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>SHEPARDSTOWN, WEST VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PUMPHREY, INC.</b> ADDRESS <b>SILVER SPRING, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 27 '61</b>		24b. REGISTRAR'S SIGNATURE <b>William L. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

4498

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04489

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>32 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Trenton</b>	
d. STREET ADDRESS <b>153 Reed Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Peter</b> First <b>Michael</b> Middle <b>Kocubinski</b> Last		4. DATE OF DEATH <b>April</b> Month <b>14,</b> Day <b>19</b> Year <b>61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1930</b>
9. AGE (In years lost birthday) <b>31</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic - Aircraft</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stephan Kocubinski</b>		14. MOTHER'S MAIDEN NAME <b>Helen Jankiewicz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>144-24-3989</b>	
17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACRANIAL METASTASES</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHONDROSARCOMA OF NASOPHARYNX</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>± 2 YRS</b> <b>± 2 YRS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 13, 1961</b> to <b>April 14, 1961</b> that (I) (we) last saw the deceased alive on <b>April 14, 1961</b> , and that death occurred at <b>5:42 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Haskins K. Koshima</b> M.D.		22b. DATE SIGNED <b>15 APRIL 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>HASKINS K KASHIMA</b>		22d. ADDRESS <b>National Institutes of Health The Clinical Center, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/18/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. HEDWIG'S CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>EWING TOWNSHIP, NEW JERSEY</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hyung S. Funeral Home</b>		25a. REC'D BY REGISTRAR <b>1300-N. St. N.W.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krawa</b>		25c. DATE <b>PR 17 '61</b>	

# CERTIFICATE OF BIRTH

CHORIOCARCINOMA OF NASOPHARYNX  
INTRACRANIAL METASTASES

1 YRS  
1 YRS

HASTINGS K. KASHIMA  
HASTINGS K. KASHIMA

12 APRIL 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>152 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston</b> d. STREET ADDRESS <b>R.F.D. # 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Richard</b> Last <b>Kraus</b>				4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>19 61</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 11, 1956</b>		9. AGE (In years lost birthday) yrs. <b>5</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Kendall H. Kraus</b>						14. MOTHER'S MAIDEN NAME <b>Rita Stenker</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>204</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Lymphatic Leukemia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>9 months</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>November 2, 1960</b> to <b>April 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1961</b> , and that death occurred at <b>4:30 a.m.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>X Richard E. Rieselbach</b> 22c. PHYSICIAN'S NAME (Type) <b>RICHARD E. RIESELBACH, M.D.</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4/3/61</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>April 6, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Junior Order Cemetary</b>				23d. LOCATION (City, town, or county) <b>Preston, Maryland</b> (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>APR 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4500  
MONTGOMERY  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04491

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>3 1/2 yrs.</u>		d. STREET ADDRESS <u>16th &amp; Colesville Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitorium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Belle</u> Last <u>Lantz</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 Mar. 1882</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>9</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthew Hennen</u> E. HENNEN		14. MOTHER'S MAIDEN NAME <u>Mary Louise Pickenpugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Louise L. Hexter, 3810 Everett St.</u>		Address <u>Kensington, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza</u> 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASCD</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1957</u> to <u>April 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 25, 1961</u> , and that death occurred on <u>4:25 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Horace W. Bernton</u> M.D.		22b. DATE SIGNED <u>4/26/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>HORACE W. BERTON</u>		22d. ADDRESS <u>4743 Bradley Blvd., Chevy Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/28/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EAST OAK GROVE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MORGANTOWN, WEST VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond W. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 1 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			

LEGISLATIVE

1880

(M)

THE SENATE  
JANUARY 1, 1880  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1879  
ALBANY: J. B. LANE, PRINTER.  
1880.

may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

W. BROADWAY & WILLIAMS  
BEL AIR, MD.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4501

04492

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>103 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>R.F.D. # 1</b>			
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>(None)</b> Last <b>Leatherman</b>				4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 13, 1902</b>	
9. AGE (In years lost birthday) <b>58</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemist</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin Leatherman</b>				14. MOTHER'S MAIDEN NAME <b>Barbara East</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>160-24-2593</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Gastrointestinal hemorrhage</b> 5807 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute yellow atrophy, liver</b> DUE TO (c) <b>with questionable acute myelogenous leukemia</b> ? years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 31, 1960</b> to <b>April 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 13, 1961</b> , and that death occurred at <b>5:12 a.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Jerome B. Block</b>				22b. DATE <b>4/13/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>JEROME B. BLOCK, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 17, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl. Cem. Arlington, Va.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b>				25a. REC'D BY REGISTRAR DATE <b>APR 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G292 8/1/61 ink

CERTIFICATE OF DEATH

Reg. Dist. No. 04493

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> <u>Bellmont - Ashton, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ashton, Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashton Md.</u>				c. LENGTH OF STAY IN 1b <u>10 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bellmont Nursing Home</u>				d. STREET ADDRESS <u>Ashton, Md.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Virginia</u> First <u>Enede</u> Middle <u>Grace</u> Last <u>Le Merle</u>				4. DATE OF DEATH Month <u>4/16/61</u> Day <u>19</u> Year <u>61</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 1, 1874</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>86</u> Days <u>86</u> Hours <u>86</u> Min.		IF UNDER 24 HRS. Months <u>86</u> Days <u>86</u> Hours <u>86</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Costa Rica</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry D. Norris</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT <u>Belmont Records</u> Address <u>Ashton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Arteriosclerosis, generalized</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u> Hour a. m. <u>—</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/18/1961</u> , to <u>4/16/1961</u> , that I last saw the deceased alive on <u>4/15/1961</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald Nelson</u> M.D.				ADDRESS (Street, city or town, state) <u>10620 Georgia Ave, S/G, Md</u> DATE SIGNED <u>4/17/61</u>			
PHYSICIAN'S NAME (Type) <u>DONALD NELSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>April 17-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Saylorsville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 20 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04494

4503

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SANITARIUM &amp; HOSPITAL</b>		d. STREET ADDRESS <b>2016 GLEN HAVEN PL.</b>	
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle Last <b>Levy</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 20, 1892</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>LATVIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>LATVIA</b>	
13. FATHER'S NAME <b>BENJAMIN ROSS</b>		14. MOTHER'S MAIDEN NAME <b>ANNA ESTHER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>SIDNEY LEVY</b>		Address <b>2404 LILLIAN AVE. SE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO (b) <b>Coronary Thrombosis</b> (c) <b>atherosclerosis, generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive vascular disease</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work Not while at work <input type="checkbox"/> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/20, 1961</b> to <b>4/21, 1961</b> , that I last saw the deceased alive on <b>4/21, 1961</b> and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald Nelson</b>		ADDRESS (Street, city or town, state) <b>10620 George Ave, 4/21/61</b>	
PHYSICIAN'S NAME (Type) <b>DONALD NELSON</b>		DATE SIGNED <b>4/21/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APRIL 23, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT. LEBANON CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>W. HYATTSVILLE Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY</b>		ADDRESS <b>5501-14 Rd NW</b>	
24a. REC'D BY REGISTRAR <b>APR 25 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4504  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04495

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>4 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Congressional Manor Sanitarium</i>				d. STREET ADDRESS <i>4318 Curtis Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Sarah</i> Middle <i>Elizabeth</i> Last <i>Lloyd</i>				4. DATE OF DEATH Month <i>4</i> Day <i>7</i> Year <i>1961</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 2, 1877</i>	
9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Wesley Adams</i>				14. MOTHER'S MAIDEN NAME <i>Ellen Thompson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. John D. Lloyd</i> Address <i>Law</i> <i>Daughter-in</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchial pneumonia</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebrovascular accident</i> DUE TO <i>arteriosclerosis, generalized</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> <i>4 weeks</i> <i>10 years</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 1957</i> to <i>April 7, 1961</i> , that (I) (we) last saw the deceased alive on <i>April 7, 1961</i> , and that death occurred at <i>3:25 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert N. Coale</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT N. COALE</i>				22d. ADDRESS <i>4630 Montgomery Ave. Bethesda, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/11/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>				25a. REC'D BY REGISTRAR DATE <i>APR 12 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

CENTRAL STATE OF DEATH

1880

(M)

Congressional Representative; also served as  
Baltimore

James M. Smith  
Feb 2, 1871

(T)

John M. Smith  
Mar 1, 1871

John M. Smith  
Mar 1, 1871

John M. Smith  
Mar 1, 1871

John M. Smith  
Mar 1, 1871

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

4505  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04496

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>5721-Crossman Lane</i>	
3. NAME OF DECEASED (Type or print) <i>JAMES</i> First Middle Last <i>LOWE</i>		4. DATE OF DEATH Month <i>4</i> Day <i>26</i> Year <i>1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1880</i>
9. AGE (In years lost birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Accountant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dept. of Internal S. Carolina</i>	
11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Madison Lowe</i>		14. MOTHER'S MAIDEN NAME <i>Taylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no.</i>		16. SOCIAL SECURITY NO. <i>no.</i>	
17. INFORMANT <i>son</i> Address <i>James Lowe, 5705 N. 44th St. Bethesda, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Pyelonephritis</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1957</i> to <i>April 26, 1961</i> , that (I) (we) last saw the deceased alive on <i>4-26</i> 19 <i>61</i> , and that death occurred at <i>9:30 P.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>James W. Egan</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>7720 Wisconsin Ave. Bethesda Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/29/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek</i>		23d. LOCATION (City, town, or county) (State) <i>WASH. D. C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Timothy Nanton</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 5 '61</i>	
ADDRESS <i>3831-GA. Ave NW</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

CERTIFICATE OF DEATH

3008

(M)

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. Some words like "I AM" and "W" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
4506  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04497

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>32 da</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bermtown</u> d. STREET ADDRESS <u>1 R+2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Audrey Lee Hovary</u>				4. DATE OF DEATH <u>April 18</u> 19 <u>61</u> Month Day Year											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1946</u>		9. AGE (In years lost birthday) <u>15</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Leon Lowery</u>				14. MOTHER'S MAIDEN NAME <u>Crimes</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Leon Lowery as above.</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Emboli, Kidney, Brain</u> 401.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Subacute BACTERIAL Endocarditis</u> DUE TO (c) <u>Rheumatic HEART DISEASE</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>1 mo</u> <u>6 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>4/15/1961</u> to <u>4/18/1961</u> , that (I) (we) last saw the deceased alive on <u>4/18/1961</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>Allen J. O'Neill</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill MD</u>				22d. ADDRESS <u>8601 Old Georgetown Rd, Bethesda MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Church Cem.</u>				23d. LOCATION (City, town, or county) (State) <u>Darnestown, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>				ADDRESS <u>Funeral Home-1331 E. Montg. Ave. Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 24 '61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>					

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*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "first" and "last" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4507

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04498

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Connecticut</b> b. COUNTY <b>Trumbull</b> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>115 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Trumbull</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>27 Bear Den</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Joseph</b> Last <b>Lucas</b>				4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 3, 1959</b>			
9. AGE (In years last birthday) <b>1</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.		11. IF UNDER 24 HRS. Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>			
13. FATHER'S NAME <b>Joseph E. Lucas</b>				14. MOTHER'S MAIDEN NAME <b>Rose Marie Garrison</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 204-3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Renal Failure</b> DUE TO (c) <b>Acute Lymphatic Leukemia</b>								INTERVAL BETWEEN ONSET AND DEATH <b>12 Hours</b> <b>4 Weeks</b> <b>8 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>December 14, 1960</b> to <b>April 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 8, 1961</b> , and that death occurred at <b>9:25 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Edward E. Morse</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>4-8-61</b>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Edward E. Morse</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 4-9-61</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Lawncroft Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Fairfield, Conn.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 12 '61</b>			
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

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CERTIFICATE OF DEATH

2000

(M)



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness and bleed-through.

(1)

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2000

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may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04499

4508

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Alabama</b> b. COUNTY <b>Birmingham</b>			
c. LENGTH OF STAY IN 1b <b>19 days</b>				d. STREET ADDRESS <b>817 A - 22nd Place, South</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charlie</b> Middle <b>(None)</b> Last <b>Lucious</b>				4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 August 1909</b>		9. AGE (In years last birthday) <b>52</b> yrs.	10. IF UNDER 1 YEAR Months <b>4</b> Days <b>0</b> Hours <b>X</b> Min. <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alf Lucious</b>				14. MOTHER'S MAIDEN NAME <b>Lena Howard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cryptococcal Meningitis</b> 134.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Cryptococcal Bacteremia</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Weeks</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1/Acute Myocardial Infarction. 2/Silicosis. 3/Chronic Obstructive Emphysema.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 23</b> , 19 <b>61</b> , to <b>April 11</b> , 19 <b>61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 11</b> , 19 <b>61</b> , and that death occurred at <b>7:40 PM</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>Robert R. Carpenter</b>				22b. DATE SIGNED <b>4-12-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>ROBERT R. CARPENTER, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Ship</b>		23b. DATE THEREOF <b>4-13-61</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Birmingham, Alabama</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Froger's Funeral Home Inc. 389-R.D. Ave. N.W.</b>				25a. REC'D BY REGISTRAR <b>D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

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04140

CERTIFICATE OF DEATH

2025

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THE STATE OF TEXAS, COUNTY OF DALLAS, BEFORE ME, the undersigned authority, on this 15th day of April, 1965, personally appeared \_\_\_\_\_, known to me to be the person whose name is subscribed to the foregoing instrument, acknowledged to me that he executed the same for the purposes and consideration therein expressed.

My commission expires \_\_\_\_\_.

WITNESS my hand and seal of office this 15th day of April, 1965.

Notary Public in and for the State of Texas

ATTEST: My commission expires \_\_\_\_\_.

Notary Public in and for the State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4509

## CERTIFICATE OF DEATH

04500

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>30 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Leesburg</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Route # 4, Leesburg, Va.</b> d. STREET ADDRESS <b>Route # 4, Leesburg, Va.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rossmore Denman LYON</b>		4. DATE OF DEATH Last <b>April</b> 8, 19 <b>61</b> Month <b>April</b> Day <b>8</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-14-95</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	9. AGE (In years last birthday) <b>65</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Morgan LYON</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth FAUST</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWI-WWII</b>		16. SOCIAL SECURITY NO. <b>Hospital Records</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction Myocardium, Post Operative</b> 420.1 } DUE TO Conditions, if any, which } (b) gave rise to immediate cause } (a), stating the underlying } DUE TO cause last. } (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 8, 1961</b> to <b>April 8, 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 8, 1961</b> , and that death occurred at <b>2:15 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J.W. Brown</b> M.D. <b>J.W. BROWN Lcdr MC USN</b>		22b. DATE <b>4-8-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J.W. BROWN Lcdr MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial - Arlington</b>		23b. DATE THEREOF <b>4-11-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cemetary</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b> ADDRESS <b>R.A. Pumphrey Funeral Home, Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 11 '61</b> DATE <b>Arthur S. Kline</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4510  
CERTIFICATE OF DEATH  
04501

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taroma Park</u>		c. LENGTH OF STAY IN 1b <u>5 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash SAN &amp; Hosp</u>		d. STREET ADDRESS <u>9619 Clearview Pl</u>	
3. NAME OF DECEASED (Type or print) <u>DANIEL BERNARD LYONS, JR.</u>		4. DATE OF DEATH <u>4-16-1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-06</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10. INSPECTION (Give kind of work done during most of working life, even if retired) <u>D.C. Sanitary Eng. Comm.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>DANIEL B. LYONS</u>	
14. MOTHER'S MAIDEN NAME <u>SABINA COONEY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>578-24-8671</u>		17. INFORMANT Address <u>Mrs. Louise E. Lyons, 9619 Clearview Place Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October 1955</u> to <u>April 15, 1961</u> that (I) (we) last saw the deceased alive on <u>April 15, 1961</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Bennett A. Robin</u>		22b. DATE SIGNED <u>4/17/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>BENNETT A. ROBIN</u>		22d. ADDRESS <u>317 UNIV. BLVD. EAST SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/19/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>PRINCE GEORGE COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Bumbrey, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 19 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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BENNETT A. ROGIN, M.D.  
317 UNIV BLVD. EAST  
SILVER SPRING, MD  
20 83700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4511 04502

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Northumberland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Northumberland</u>			
c. LENGTH OF STAY IN 1b <u>13 days</u>				d. STREET ADDRESS <u>9th. Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Louis</u> Middle <u>Mancini</u> Last <u>Mancini</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>26</u> Year <u>19 61</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/13/33</u>	
9. AGE (In years last birthday) <u>27 yrs.</u>		IF UNDER 1 YEAR Months <u>27</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u>27</u> Min. <u>27</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant owner</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Vincent Mancini</u>				14. MOTHER'S MAIDEN NAME <u>Earnstine Celletti</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mother</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HODGKINS DISEASE</u> DUE TO (b) <u>201X</u> Conditions, if any, which gave rise to immediate cause (c) <u>201X</u> DUE TO (e), stating the underlying cause last. (f) <u>201X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 MOS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/8</u> , 19 <u>60</u> , to <u>4/26</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4/26/1961</u> , and that death occurred at <u>2:30AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John H. Tuohy</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/26/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Tuohy, M.D.</u>				22d. ADDRESS <u>7720 WISCONSIN AVE BETHESDA 14, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/29/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Northumberland Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Sampson</u>				ADDRESS <u>7557 Wisconsin Ave. Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 28 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kincaid</u>	

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## CERTIFICATE OF DEATH

Reg. Dist. No. 04503

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
c. LENGTH OF STAY in lb <u>9 MONTH</u>		d. STREET ADDRESS <u>5605 WILSON LANE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kesner Sanatorium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>MP.</u> Middle <u>Martin</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-3-1863</u>
9. AGE (In years last birthday) <u>98</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GOVERNMENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALFRED MARTIN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH CAROLINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>MR. O. G. WHITLOW</u> Address <u>BETHESDA, MD, 5605 WILSON LANE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>---</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/20</u> 19 <u>61</u> , to <u>present</u> 19 <u>61</u> , that I last saw the deceased alive on <u>4/20</u> 19 <u>61</u> , and that death occurred at <u>12:45</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhan</u> M.D.		ADDRESS (Street, city or town, state) <u>8805 Conn Ave</u> DATE SIGNED <u>4/20/61</u>	
PHYSICIAN'S NAME (Type) <u>John B. Umhan</u>		<u>Cherry Chase 15 MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-24-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph G. Gaudin, Jr.</u> ADDRESS <u>1756 Pa. Ave NW</u>		24a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4513

04504

<b>1. PLACE OF DEATH</b> a. COUNTY Montgomery MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Norfolk			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) 15 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 799 West Ocean View Ave.			
<b>3. NAME OF DECEASED</b> (Type or print) George Eugene MARTIN, JR.				<b>4. DATE OF DEATH</b> April 20 1961			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-21-61	
9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George Eugene MARTIN, SR.				14. MOTHER'S MAIDEN NAME Janet Sue DECKER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital, Records	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from April 5 1961 to April 20 1961, that (X) (we) last saw the deceased alive on April 20 1961, and that death occurred at 8:32 PM, from the causes and on the date stated above.							
22a. SIGNATURE Fred W. Grelio M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-21-61	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELIO, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 4-22-61		23c. NAME OF CEMETERY OR CREMATORY Parkview Cemetery		23d. LOCATION (City, town or county) (State) Peoria Illinois	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., 1400 Chapin St., NW, WashDC				25a. REC'D BY REGISTRAR DATE APR 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04505

4514

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>5 1/2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rochville</b>		d. STREET ADDRESS <b>Route #1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Carl Casper May</b>				4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>Wh.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-2-1917</b>		9. AGE (in years last birthday) <b>43 yrs.</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>23</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Odd jobs</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Casper A. May</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Crider</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-018-157</b>		17. INFORMANT <b>Wilbert May (brother) Gaithersburg, Md. Route 1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive encephalopathy</b> 334X DUE TO (b) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Possible renal artery or aortic partial obstruction?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>4/18/61</b> to <b>4/22/61</b> ; that (1) (we) last saw the deceased alive on <b>4/22/61</b> , and that death occurred at <b>4:50 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Allen J. O'Neill MD.</b>				22b. DATE SIGNED <b>4/22/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Allen J. O'Neill MD.</b>	
22d. ADDRESS <b>8601 Old Georgetown Rd, Bethesda MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-25-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Montgomery Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis K. Barber</b>				25a. REC'D BY REGISTRAR DATE <b>APR 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(I)

334X

Handwritten notes in the center of the page, including the word "Hypertension" and other illegible text.

Handwritten notes at the bottom of the page, including "Chest X-ray" and "Hypertension".

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04506**

**4515**

FOR STATE  
HEALTH DEPT.

**(M)**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4809 Middlesex Lane, Bethesda</b>			d. STREET ADDRESS <b>4809 Middlesex Lane</b>		
3. NAME OF DECEASED (Type or print) First <b>Ronald</b> Middle <b>Walter</b> Last <b>May</b>			4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>19 61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1922</b>		9. AGE (In years last birthday) <b>38</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newspaper reporter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>		11. BIRTHPLACE (State or foreign country) <b>Brooklyn, New York</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Nicholas Bradford May</b>			14. MOTHER'S MAIDEN NAME <b>Renata Zich May</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Jeanne Smith May</b>		Address <b>4809 Middlesex Lane</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>April 3, 1961</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-6-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cem.</b>		22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PHMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 6 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>



## CERTIFICATE OF DEATH

Reg. Dist. No.

04507

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D.C.</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hava Rest Nursing Home</b>				d. STREET ADDRESS <b>1618 22nd Street S.E.</b>			
3. NAME OF DECEASED (Type or print) First <b>Ella</b> Middle <b>Rose</b> Last <b>Mayhugh</b>				4. DATE OF DEATH Month <b>April</b> Day <b>9th</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 31st 1872</b>	9. AGE (In years last birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months <b>72</b> Days <b>10</b> Hours <b>10</b> Min.	IF UNDER 24 HRS. Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Burke</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Brady</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs Nellie Cogan 1618 22nd St. S.E. Wash. D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary arterio-sclerosis</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>72 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct-7</b> , 19 <b>60</b> , to <b>April 9</b> , 19 <b>61</b> , that I lost saw the deceased alive on <b>April 9</b> , 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. Chester Brady</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>35-244 Ave NW</b>			
PHYSICIAN'S NAME (Type) <b>J. Chester Brady, M.D.</b>				M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/12/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gainesville Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Gainesville Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>NW Chambers Co.</b>				ADDRESS <b>517 11th St. S.E. Washington D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	
				24a. REC'D BY REGISTRAR <b>DATE APR 11 '61</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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4517  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04508

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN 1b <b>unobtainable</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>4615 44th Street N.W., Wash., D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lillie</b> Middle <b>McAlexander</b> Last <b>McAlexander</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5, 1882</b>	9. AGE (In years lost birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia, U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Thomas Spencer</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Kensington, Md.</b> <b>Sanitarium records 3000 McComas Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia and Pyelonephritis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congestive heart failure</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 days</b> <b>unknown</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Kyphoscoliotic Pulmonary Disease, 70 years.</b>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>3-6</b> 19 <b>59</b> to <b>4-29</b> 19 <b>61</b> , that (I) (we) lost saw the deceased alive on <b>4-29</b> 19 <b>61</b> , and that death occurred at <b>8:34</b> A.M. from the causes and on the date stated above.					
22a. SIGNATURE <b>Edward W. Youngblood</b>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>EDWARD W. YOUNGBLOOD</b>	
22d. ADDRESS <b>WASHINGTON CLINIC, WASHINGTON, D.C.</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>5/2/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Shipman, Virginia</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>MAY 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>28 hrs</u>				d. STREET ADDRESS <u>11602 GAIL ST</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San + Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Agnes Elizabeth McCaffrey</u>				4. DATE OF DEATH <u>Apr 8 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-6-1903</u>	
9. AGE (In years, last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CASHIER &amp; Engraving</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CASHIER &amp; Engraving</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Printing &amp; Engraving, U.S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>JOHN J. BOYD</u>				14. MOTHER'S MAIDEN NAME <u>IDA unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hosp. Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) <u>1st 2nd &amp; 3rd degree burn involving 80% body</u> DUE TO (c) <u>29 hrs</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Clothes caught afire while burning trash at home</u>			
20c. TIME OF INJURY Month, Day, Year <u>3:08 p.m. 4-7 1961</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>md</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>4-9-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/15/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR <u>WERNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>APR 19 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



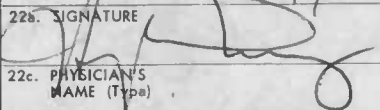
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4519

04510

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>15 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>2501 Van Buren Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
3. NAME OF DECEASED (Type or print) <b>Maude Lister McCahan</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1961</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 7, 1875</b>		9. AGE (in years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE MD</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>																							
13. FATHER'S NAME <b>Glen Rust</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Lister</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT <b>Washington Sanitarium and Hospital</b> Address															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>578X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Disastro Intestinal Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Hypertension + ASD to congestive failure</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <b>4/3</b>				20g. (County) <b>1961</b>				20h. (State) <b>4/4</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>4/3</b> , 19 <b>61</b> , to <b>4/4</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/3</b> , 19 <b>61</b> , and that death occurred at <b>12:30</b> A.M., from the causes and on the date stated above.																															
22a. SIGNATURE 								22b. DATE SIGNED <b>4/4/61</b>																							
22c. PHYSICIAN'S NAME (Type) <b>Wm. Cook, Inc., 1217 St. Paul St., Baltimore 2</b>								22d. ADDRESS <b>7105 RIGGS RD. HYATTSVILLE, MD</b>																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/7/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore County, Md.</b>																			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul St., Baltimore 2</b>								25a. REC'D BY REGISTRAR DATE <b>APR 5 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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04511

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>34 hr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS <u>15 Water St Apt 4A</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>DAVID RUSSELL Mc CATHAM</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>April 7 1961</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>APRIL 5 1961</u>		<b>9. AGE</b> (In years last birthday) <u>9 yrs.</u> IF UNDER 1 YEAR: Months <u>1</u> Days <u>10</u> Hours <u>10</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>				<b>13. FATHER'S NAME</b> <u>Rodney Rathbone Mc Catham</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Carole Lee Frye</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Mother -</u> Address <u>15 Water St Apt 4A Gaithersburg</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>4-6-1961</u> to <u>4-7-1961</u>, that (I) (we) last saw the deceased alive on <u>4-7-1961</u>, and that death occurred at <u>9:55A</u>, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Roger H. Bergstrom</u> M.D.				<b>22b. DATE SIGNED</b> <u>APR 11 '61</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Roger H Bergstrom</u>				<b>22d. ADDRESS</b> <u>Rockville Medical Bldg. Rockville, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4-9-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Forest Oak Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Gaithersburg MD</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John S. Sartin</u>				<b>25a. REC'D BY REGISTRAR</b> <u>APR 11 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>				<b>25c. ADDRESS</b> <u>316 E. Diamond Gaithersburg MD</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Montgomery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4521

04512

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 122 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Tennessee b. COUNTY Tennessee c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington d. STREET ADDRESS 6952 Navy Road			
3. NAME OF DECEASED (Type or print) RUSSELL DUANE MC CRACKEN		4. DATE OF DEATH April 17 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-24	9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (County & State, or foreign country) Michigan	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George MC CRACKEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII-Korean		16. SOCIAL SECURITY NO. 385-14-2237		17. INFORMANT (W) Mrs. Dona C. McCracken, same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic sarcoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (X) (this hospital) attended the deceased from Dec. 16 1960 to April 17 1961, that (X) (we) last saw the deceased alive on April 17 1961, and that death occurred at 4 AM, from the causes and on the date stated above.					
22a. SIGNATURE J. H. Miller		22b. DATE 4-17-61		22c. PHYSICIAN'S NAME (Type) J. H. MILLER, LT, MC, USNR	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 4-18-61		23b. DATE THEREOF 4-18-61		23c. NAME OF CEMETERY OR CREMATORY Memphis National Cem.	
23d. LOCATION (City, town or county) Memphis		23e. (State) Tenn.			
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		24b. ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR APR 19 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanks					



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
4522 CERTIFICATE OF DEATH 04513														
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington									
c. LENGTH OF STAY IN lb 1 1/2 hrs.					d. STREET ADDRESS 3601 Nichols Ave., S. E.									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Annie Will MC MILLAN					4. DATE OF DEATH April 25 1961									
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-10-23		9. AGE (In years last birthday) 37 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME Curtis KINGRY					14. MOTHER'S MAIDEN NAME Ethie COOLEY									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 422-16-3653					17. INFORMANT (H) Leon D. McMillan, same as #2 above				
18. CAUSE OF DEATH (Enter only one cause per line, or (e), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 464X DUE TO Conditions, if any, which gave rise to immediate cause (b) Thrombophlebitis (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Acute Bacterial Endocarditis										INTERVAL BETWEEN ONSET AND DEATH 12 hours Unknown duration				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (H) (this hospital) attended the deceased from April 25, 1961 to April 25, 1961, that (H) (we) last saw the deceased alive on April 25, 1961, and that death occurred at 1:07 PM, from the causes and on the date stated above.														
22a. SIGNATURE J. M. YOUNG, LT, MC, USN					22b. DATE SIGNED 4-25-61									
22c. PHYSICIAN'S NAME (Type) J. M. YOUNG, LT, MC, USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Shipment		23b. DATE THEREOF 4-26-61		23c. NAME OF CEMETERY OR CREMATORY Cottonwood Cemetery		23d. LOCATION (City, town or county) Cottonwood Ala.		23e. REC'D BY REGISTRAR APR 28 '61						
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 517 11th St., SE, WashDC					25b. REGISTRAR'S SIGNATURE Arthur S. Kline									

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04514

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>DOA.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville 33</u> d. STREET ADDRESS <u>12709 Robindale Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Frank</u> First <u>McMillen</u> Middle <u>—</u> Last		<b>4. DATE OF DEATH</b> <u>April 22, 1961</u>		Month <u>April</u> Day <u>22</u> Year <u>1961</u>			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>11/7/1896</u>		<b>9. AGE</b> (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS.: Hours <u>—</u> Min. <u>—</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Superintendent</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Govt.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>James G. McMillen</u>					
<b>14. MOTHER'S M maiden NAME</b> <u>Ray</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>1921-1924</u>					
<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> <u>Abbie K. McMillen, same as above.</u> Address <u>—</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cardiac arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary arteriosclerosis</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Seconds</u> <u>Several years</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>—</u> p.m. <u>—</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>August 1956</u> <u>April 1961</u> , that (I) (we) last saw the deceased alive on <u>4/14</u> <u>1961</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Jack Segal</u>		<b>22b. DATE SIGNED</b> <u>4/22/61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Jack Segal</u>			
<b>22d. ADDRESS</b> <u>5323 Connecticut Ave W.W.</u>		<b>22e. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4/26/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Arlington, Virginia</u>		<b>23e. REC'D BY REGISTRAR</b> <u>APR 25 '61</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tyson Wheeler Funeral Home</u>		<b>25. ADDRESS</b> <u>1331 E. Montgomery Avenue Rockville, Maryland</u>					

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "National", "Admission", and "Registration" are faintly visible.]*

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4524

04515

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>2 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>24 Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>222 Dale Dr.</u>				d. STREET ADDRESS <u>1222 Dale Dr</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Daniel Meyer</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-25-1880</u>	
9. AGE (In years last birthday) <u>81 yrs.</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Edward Meyer</u>				14. MOTHER'S MAIDEN NAME <u>Susan Hudson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>1-25-1880</u>		17. INFORMANT <u>Martha Meyer (wife)</u> Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C.A. of colon - post operative</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus 20 yrs</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>4 mo.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>4-2-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>Cremation</u>		<u>4/2/61</u>		<u>Ft. Lincoln Crematory</u>		<u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR <u>The S.H. Hines Co., 2901 14th St. N.W.,</u>				24a. REC'D BY REGISTRAR <u>APR 4 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

Page 4

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04516

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>7yr. 7mo.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Silver Spring</u> d. STREET ADDRESS <u>1321 Benwood Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Margaret Woods Meryl</u>		4. DATE OF DEATH Month Day Year <u>April 12 1961</u>	
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 25, 1912</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>L.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANDREW Van Woods</u>		14. MOTHER'S MAIDEN NAME <u>WILLOMENIA KELLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Vanada J. Meryl</u> Address <u>Apt. 208 2321 Blue Ridge Rd. Washington, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation (Laryngospasm)</u> 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Sclerosis - progressing +</u> DUE TO <u>Terminal (Laryngospasm-Terminal)</u> (c) <u>8 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 28, 1953</u> to <u>April 12 1961</u> , that (I) (we) last saw the deceased alive on <u>March 28 1961</u> , and that death occurred at <u>7:45</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>John B. Ziegler</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12 April 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>		22d. ADDRESS <u>OLNEY MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/14/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 19 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1918

OFFICE OF THE SECRETARY

WASHINGTON



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U. S. DEPT. OF AGRICULTURE  
WASHINGTON, D. C.

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

04517

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>14 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>46 Bethesda</u> d. STREET ADDRESS <u>1880 Ridge Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MARTHA</u> Middle <u>M</u> Last <u>Miller</u>		<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 16, 1875</u>
9. AGE (in years last birthday) <u>86 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Jerome Fridinger</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hughes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>	
17. INFORMANT <u>Hertude Hoke (daughter)</u>		18. ADDRESS <u>same as above</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, posterior</u> <u>420.1</u> DUE TO (b) <u>Arteriosclerosis, Severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Encephalomalacia, Left Internal Capsule</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>April 3</u> , 19 <u>61</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>April 3</u> , 19 <u>61</u> , and that death occurred at <u>9:00</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Jack Crowell</u>		22b. DATE SIGNED <u>4/3/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JACK CROWELL</u>		22d. ADDRESS <u>2025 Eye St., N.W. Washington, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenhill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Martinsburg, West Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Murphy</u>		25a. REC'D BY REGISTRAR <u>  </u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		DATE <u>APR 10 '61</u>	

(M)

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Robert A. Lawrence, Secretary  
Greenhill Cemetery, New York  
4/1/11

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 is to be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4527											
04518											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <b>11114 Dewey Road</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11114 Dewey Road</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>SUE</b>						First		Middle <b>MITOMA</b>		Last	
4. DATE OF DEATH <b>4 17 19 61</b>						Month		Day		Year	
5. SEX <b>female</b>		6. COLOR OR RACE <b>Japanese</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/25/91</b>		9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>FUKUOKA, JAPAN</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Izuya Takagi</b>						14. MOTHER'S MAIDEN NAME <b>Kiyo Kido</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>						16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Poshicho Mitoma - Kensington, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>JAN. 10, 19 56</b>		20g. (County) <b>APRIL 17, 19 61</b>		20h. (State) <b>MD.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4/17</b> 19 <b>61</b> to <b>APRIL 17, 19 61</b> , that (I) <b>9P</b> last saw the deceased alive on <b>4/17</b> 19 <b>61</b> , and that death occurred at <b>9P</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>John E. Everett</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>JOHN E. EVERETT</b>						22d. ADDRESS <b>9400 CONN. AVE KENSINGTON MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>4/21/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>				23d. LOCATION (City, town or county) (State) <b>Prince Georges Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co.</b>						ADDRESS <b>Washington, D. C.</b>		25a. REC'D BY REGISTRAR <b>DATE APR 19 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

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The S.H. Hines Co. Washington, D. C.  
Operation 11-11-11  
Prince Georges Co. Md.

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4528  
MONTGOMERY STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04519

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillandale, Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillandale, Silver Spring</i>	
c. LENGTH OF STAY IN 1b <i>23 years</i>		d. STREET ADDRESS <i>10,306 Nagle Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10,306 Nagle Road</i>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Wallace</i> Middle <i>Nevin</i> Last <i>Mook</i>		4. DATE OF DEATH Month <i>April</i> Day <i>13</i> Year <i>1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 10, 1910</i>
9. AGE (In years last birthday) <i>50</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Physician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>M.D.</i>	
11. BIRTHPLACE (State or foreign country) <i>Ambridge, Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. of America</i>	
13. FATHER'S NAME <i>Edward Dennis Mook</i>		14. MOTHER'S MAIDEN NAME <i>Edna Lillian Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>READ N. CALVERT, M.D.</i>		Address <i>909 Pershing Dr., Silver Spring, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Plasma cell Myeloma</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>203X</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>8 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Boney Metastasis with Pathological Fractures.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>April 1956</i> to <i>April 13, 1961</i> , that (I) (we) last saw the deceased alive on <i>April 12, 1961</i> , and that death occurred at <i>7:24 P.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Read N. Calvert, M.D.</i>		22b. DATE SIGNED <i>April 13, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Read N. Calvert, M.D.</i>		22d. ADDRESS <i>909 Pershing Dr., Suite 107, Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>April 17, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Prima George Co. Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters, 254 Carroll St NW</i>		25a. REC'D BY REGISTRAR DATE <i>APR 18 '61</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

I

X

M

909

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b> c. LENGTH OF STAY IN 1b <b>18 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>White Water - Potomac River</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westmoorland Hills</b> d. STREET ADDRESS <b>5236 Duvall Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>Caldwell</b> Last <b>Moore</b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/22/14</b>
9. AGE (In years last birthday) <b>43 4/8 yrs.</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>8</b>	IF UNDER 24 HRS. Hours <b>4</b> Min. <b>8</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hiram S. Caldwell</b>		14. MOTHER'S MAIDEN NAME <b>Nellie McCormick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no...</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Thornton B. Moore-Husband-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>929.8</b> DUE TO <b>drowning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Unknown-Dissappeared at Seneca, Md. 3/29/61</b>	
20c. TIME OF INJURY Month, Day, Year <b>3/29 1961</b> Hour <b>?</b> a. m. <b>?</b> p. m. <b>?</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Potomac River</b>		20f. (City or town) <b>Seneca, Montgomery, Md.</b> (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>4/22/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>4/22/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) <b>Seneca, Md.</b> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Paulsen's Sons, 1756 P. Ave. N.W.</b>		ADDRESS _____	
24a. REC'D BY REGISTRAR <b>APR 25 '61</b>		DATE _____	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
RACE [REDACTED]		DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]	
OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]		DATE OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		SIGNATURE OF EXAMINER [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF NEXT OF KIN [REDACTED]		SIGNATURE OF CLERK [REDACTED]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
4530											
04521											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. LENGTH OF STAY IN 1b <u>2 days</u>					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						d. STREET ADDRESS <u>48 Philadelphia Ave</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San &amp; Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Josephine</u> First Middle Last						4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1961</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-12-81</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Deleware</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Isaac Watson</u>						14. MOTHER'S MAIDEN NAME <u></u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u></u>					
17. INFORMANT <u>Daughter - (Mrs Betty Hurley)</u>						Address <u>6425-14th St N.W. DC</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CONGESTIVE HEART FAILURE</u> (c) <u>BRONCHOPNEUMONIA &amp; ANEMIA</u>										INTERVAL BETWEEN ONSET AND DEATH <u>UNDETERMINED</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MARKED CAHEXIA</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u>		(County) <u></u>		(State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>4-11-61</u> , 19 <u>61</u> , to <u>4-13</u> , 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>4-13</u> , 19 <u>61</u> , and that death occurred at <u>9:45</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Morrill C. Quinnam</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>4-13-61</u>		
22c. PHYSICIAN'S NAME (Type) <u>Morrill C. Quinnam</u>						22d. ADDRESS <u>7600 Carroll Ave. Takoma Park, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>			23b. DATE THEREOF <u>4/15/61</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Pt. Lincoln Crematory</u>			23d. LOCATION (City, town or county) (State) <u>Prince Georges, Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sh S H. H. H. G.</u>						25a. REC'D BY REGISTRAR <u>2901 14th St N.W. Wash 9, D.C.</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		
DATE <u>APR 14 '61</u>											

0523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
4531  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04522

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>7 hrs; 5 min</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha Eureka Morgan</b>				4. DATE OF DEATH Month Day Year <b>April 14 19 61</b>															
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1873</b>		9. AGE (In years last birthday) <b>87</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				11. BIRTHPLACE (State or foreign country) <b>Indiana</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry L. Rucker</b>				14. MOTHER'S MAIDEN NAME <b>Susan Anis Siler</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>				17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5705</b> <b>intestinal obstruction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>T</b> DUE TO (c) <b>T</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 9 19 61</b> to <b>April 14 19 61</b> , that (I) (we) last saw the deceased alive on <b>April 14 19 61</b> and that death occurred at <b>7/35 P.M.</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>John P. Martin</b> 22b. DATE SIGNED <b>4/14/61</b>																			
22c. PHYSICIAN'S NAME (Type) <b>John P. Martin, M. D.</b> <b>XXXXXXXXXXXXXXXXXXXX</b> 22d. ADDRESS <b>Sandy Spring, Maryland</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/17/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Arlington, Indiana</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b> ADDRESS <b>Laytonsville, Md.</b>																			
25a. REC'D BY REGISTRAR DATE <b>APR 17 '61</b>								25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

4532

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04523

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>30 Silver Spring, Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. Lan. &amp; Hosp.</i>				d. STREET ADDRESS <i>10005 Jenbrook</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Percy</i> Middle <i>Nelson</i> Last <i>Moulden</i>				4. DATE OF DEATH Month <i>April</i> Day <i>5</i> Year <i>1961</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 3, 1876</i>	
9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR Months <i>8</i> Days <i>15</i>		IF UNDER 24 HRS. Hours <i>15</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>master machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>District Gov.</i>		11. BIRTHPLACE (State or foreign country) <i>Rockville, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>	
13. FATHER'S NAME <i>Eliah</i> <i>Stacy Moulden</i>				14. MOTHER'S MAIDEN NAME <i>Martha unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>yes</i>		16. SOCIAL SECURITY NO. <i>216-80-3887</i>		17. INFORMANT <i>Ma Mary Vanwert</i> Address <i>10005 Jenbrook - Silver Spring, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage with left hemiplegia</i> 433-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic degenerated myocarditis with</i> DUE TO <i>auricular fibrillation.</i> (c) <i>3 days</i> <i>4 yrs.</i> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/26</i> 19 <i>45</i> to <i>4/5</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>4/5</i> 19 <i>61</i> , and that death occurred at <i>11 A.</i> M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Howard T. Morse</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Howard T. Morse, M.D.</i>				22d. ADDRESS <i>7030 Carroll Ave, Takoma Park-12, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>4/10/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT'L. CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Pumphrey, Inc.</i> <i>Raymond E. Pumphrey</i>				ADDRESS <i>SILVER SPRING, MD.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 11 '61</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

CERTIFICATE OF DEATH

(M)

(I)

22

UNITED STATES DEPARTMENT OF HEALTH

WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04524

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARY LAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 CHEVY CHASE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3525 WOODBINE STREET</b>		d. STREET ADDRESS <b>3525 WOODBINE STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALLENE</b> Middle <b>C.</b> Last <b>MULVEY</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 28, 1886</b> 9. AGE (In years lost birthday) <b>75</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SECRETARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON, D. C.</b> 11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
13. FATHER'S NAME <b>HUGH A. ERNST</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA E. HAMILTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>577-03-2379</b> 17. INFORMANT <b>FRANCIS J. MULVEY</b> Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1930 Carcinoma of Blain</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>primarily carcinoma of esophageal lobe</b> DUE TO (c) <b>7 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/29, 1960</b> to <b>Apr 17, 1961</b> , that I last saw the deceased alive on <b>Apr 16, 1961</b> , and that death occurred at <b>3:25 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3100 CONNECTICUT AVE. N.W.</b> DATE SIGNED <b>4/17/61</b>			
ACTUAL SIGNATURE <b>Joan V. Dolan</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOHN V. DOLAN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-19-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b> ADDRESS <b>WASH. D.C. 3821 14TH. ST. N.W.</b>		24a. REC'D BY REGISTRAR <b>APR 18 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		PROFESSION		INDUSTRY		BUSINESS		ART		SCIENCE		LITERATURE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		POSTGRADUATE		OTHER					
RELIGION		METHODIST		BAPTIST		CATHOLIC		PROTESTANT		OTHER					
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER							
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		OTHER					
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY					
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF WITNESS							
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CITY		STATE		COUNTRY					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

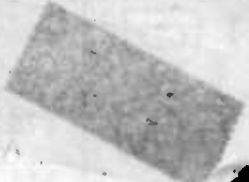
VR AIS (4)  
15M 9/59

1  
4534

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04525

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b <b>33 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>47X-3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN Hospital</b>		d. STREET ADDRESS <b>3721 49th ST. N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>PERMELIA CATHRYN MUMFORD</b>		4. DATE OF DEATH <b>3:35 PM April 25 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 22 1906</b>
9. AGE (In years lost birthday) <b>54 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>BRAVORD Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALBERT P. STEVENS</b>		14. MOTHER'S MAIDEN NAME <b>CATHARINE Callinan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. L. O. Mumford (husband)</b>		Address <b>as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>581.0</b> IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> DUE TO (b) <b>Portal Cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1956</b> to <b>April 25, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 25, 1961</b> , and that death occurred at <b>3:35 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph H. Watson</b>		22b. DATE SIGNED <b>4/25/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joseph H. Watson</b>		22d. ADDRESS <b>3201 Wisconsin Ave. Wash D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 4/26/61</b>		23b. DATE THEREOF <b>4/26/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>East Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>East Haven, Connecticut</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>APR 27 '61</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>	



(1)

CHELETAVIM

Robert A. Hughes, Bethesda, Maryland  
Barry J. Smith, 4301 East 1st Avenue, Stamford, Connecticut

Joseph E. Watson

Handwritten notes and signatures, including "W. J. Smith" and "Barry J. Smith".

CERTIFICATE OF DEATH

1934

11522

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. For Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained to your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

<div> <div> <div>1</div> <div>4535</div> </div> <div> <div>Item 22a</div> <div>Film G286</div> <div>5/8/61</div> <div>3WK</div> </div> </div> <div> <div> <div>45830</div> <div>u5830</div> </div> </div>											
<div> <div> <div>1</div> <div>4535</div> </div> <div> <div>Item 22a</div> <div>Film G286</div> <div>5/8/61</div> <div>3WK</div> </div> </div> <div> <div> <div>45830</div> <div>u5830</div> </div> </div>											
<div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Montgomery</div> <div>MARYLAND</div> </div>						<div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>D.C.</div> <div>b. COUNTY</div> <div>Washington</div> </div>					
<div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Bethesda</div> <div>c. LENGTH OF STAY in 1b</div> <div>4 hrs</div> </div>						<div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>WASHINGTON</div> <div>d. STREET ADDRESS</div> <div>1436 Howard Rd. S.E.</div> </div>					
<div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Suburban Hosp.</div> </div>						<div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>					
<div> <div>3. NAME OF DECEASED (Type or print)</div> <div>Dorothy</div> <div>First</div> <div>Nelson</div> <div>Middle</div> <div>Last</div> </div>						<div> <div>4. DATE OF DEATH</div> <div>Apr</div> <div>26</div> <div>1961</div> </div>					
<div> <div>5. SEX</div> <div>F</div> </div>		<div> <div>6. COLOR OR RACE</div> <div>Col</div> </div>		<div> <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></div> </div>		<div> <div>8. DATE OF BIRTH</div> <div>3/21/26</div> </div>		<div> <div>9. AGE (In years last birthday)</div> <div>35 yrs.</div> </div>		<div> <div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div> </div>	
<div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Housewife</div> </div>						<div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div></div> </div>					
<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>WASH D.C.</div> </div>						<div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div> </div>					
<div> <div>13. FATHER'S NAME</div> <div>William H. Brown</div> </div>						<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Mildred Jones</div> </div>					
<div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div></div> </div>						<div> <div>16. SOCIAL SECURITY NO.</div> <div></div> </div>					
<div> <div>17. INFORMANT</div> <div>Gerald B Nelson (Husband) Same as above</div> </div>						<div> <div>Address</div> <div></div> </div>					
<div> <div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Irreversible shock</div> <div>823X</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>(b)</div> <div>Fractured cervical vertebrae</div> <div>(c)</div> <div>Automobile accident</div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>Pregnancy (7 Mos)</div> <div>Driver of car which left highway + struck tree</div> </div>											
<div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> </div>											
<div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour</div> <div>11:24 p.m.</div> <div>4-25-1961</div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/></div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>Highway</div> <div>20f. (City or town)</div> <div>Norfolk</div> <div>(County)</div> <div>Montg</div> <div>(State)</div> <div>Md</div> </div>											
<div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</div> <div>Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> </div>											
<div> <div>ACTUAL SIGNATURE</div> <div>Frank J. Blaschert</div> </div>						<div> <div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>DATE SIGNED</div> <div>4-26-61</div> </div>					
<div> <div>EXAMINER'S NAME (Type)</div> <div>FRANK J. BLASCHERT</div> </div>						<div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>Address (Street, city, town, or country)</div> <div></div> </div>					
<div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> </div>		<div> <div>22b. DATE THEREOF</div> <div>Apr 29-61</div> </div>		<div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>mt Olivet cemetery</div> </div>		<div> <div>22d. LOCATION (City, town, or country)</div> <div>DC</div> </div>		<div> <div>24a. REC'D BY REGISTRAR</div> <div>4/29/61</div> </div>		<div> <div>24b. REGISTRAR'S SIGNATURE</div> <div>Arthur S. Knease</div> </div>	
<div> <div>23. FUNERAL DIRECTOR</div> <div>Address</div> <div>Haller E. Hunter Wash. DC</div> </div>						<div> <div>DATE</div> <div>4/29/61</div> </div>					

MAY 2 '61

Arthur S. Knease



05830

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

DATE: [Illegible]

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

30. [Illegible]

31. [Illegible]

32. [Illegible]

33. [Illegible]

34. [Illegible]

35. [Illegible]

36. [Illegible]

37. [Illegible]

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39. [Illegible]

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41. [Illegible]

42. [Illegible]

43. [Illegible]

44. [Illegible]

45. [Illegible]

46. [Illegible]

47. [Illegible]

48. [Illegible]

49. [Illegible]

50. [Illegible]

51. [Illegible]

52. [Illegible]

53. [Illegible]

54. [Illegible]

55. [Illegible]

56. [Illegible]

57. [Illegible]

58. [Illegible]

59. [Illegible]

60. [Illegible]

61. [Illegible]

62. [Illegible]

63. [Illegible]

64. [Illegible]

65. [Illegible]

66. [Illegible]

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68. [Illegible]

69. [Illegible]

70. [Illegible]

71. [Illegible]

72. [Illegible]

73. [Illegible]

74. [Illegible]

75. [Illegible]

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77. [Illegible]

78. [Illegible]

79. [Illegible]

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81. [Illegible]

82. [Illegible]

83. [Illegible]

84. [Illegible]

85. [Illegible]

86. [Illegible]

87. [Illegible]

88. [Illegible]

89. [Illegible]

90. [Illegible]

91. [Illegible]

92. [Illegible]

93. [Illegible]

94. [Illegible]

95. [Illegible]

96. [Illegible]

97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1  
4536  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04526

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>47X-3</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SAN. HOSP</u>		d. STREET ADDRESS <u>628 HAMILTON ST. NW</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLIFTON CLAY NIBLOCK</u>		4. DATE OF DEATH Month Day Year <u>April 14 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1894</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired DC Gov</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANKLIN NIBLOCK</u>		14. MOTHER'S MAIDEN NAME <u>FRANCE RENSHAW</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW 1 any</u>	
17. INFORMANT <u>Louise N. Niblock</u>		Address <u>628 Hamilton NW</u>	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>493X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June, 1960</u> , to <u>4/14, 1961</u> , that I last saw the deceased alive on <u>4/13, 1961</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald Nelson</u>		ADDRESS (Street, city or town, state) <u>10620 Georgia Ave Silver Spring, Md</u>	
M.D. <u>4/14/61</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 18, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u>		ADDRESS <u>4812 Dakota NW</u>	
24a. REC'D BY REGISTRAR <u>APR 19 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

CERTIFICATE OF DEATH

1. Name of deceased: James H. Smith  
2. Age: 68  
3. Sex: Male  
4. Date of death: Dec 15 1900  
5. Place of death: New York City  
6. Cause of death: Heart Disease  
7. Signature of physician: John H. Smith  
8. Signature of witness: John H. Smith  
9. Signature of registrar: John H. Smith  
10. Signature of undertaker: John H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4557

04527

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montg</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boysds (Rural)</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boysds (Rural)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Oliver</u> Middle <u>Nicholson</u> Last <u>Nicholson</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>17</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 11-1873</u>	
9. AGE (in years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Montg. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gardining</u>			
13. FATHER'S NAME <u>Hamilton Nicholson</u>				14. MOTHER'S MAIDEN NAME <u>Delilah Andrews</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				17. INFORMANT <u>Arthur R. Tapp.</u> Address <u>Washington, D C.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Disease (CVA)</u> 331X DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Lower Gastrointestinal Hemorrhaging Chronic course und.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lower Gastrointestinal Hemorrhaging Chronic course und.</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 year</u>							
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 11, 1954</u> to <u>12 Apr., 1961</u> , that (I) (we) last saw the deceased alive on <u>16 Apr. 1961</u> , and that death occurred at <u>8:49</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Gordon M Smith</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <u>Barnesville, Md</u>		22b. DATE SIGNED <u>18 Apr 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gordon M Smith</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-20-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hyattstown Methodist Ch. Hyattstown, Md.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

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*John Smith*

*John Smith*

James O. Gartner, Baltimore, Md.

James O. Gartner

4-28-61

James O. Gartner, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 shall be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4538

## CERTIFICATE OF DEATH

04528

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Fairland Nursing Home</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>1615 Flora Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Rose E. Nicholson</b>		<b>4. DATE OF DEATH</b> Month <b>4</b> Day <b>28</b> Year <b>1961</b>	
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9/21/1897</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D. C.</b>	
<b>13. FATHER'S NAME</b> <b>William Moop</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary A. Langley</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <b>Hospital records</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>3 years</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>Feb 1</b> 19 <b>50</b> to <b>April 28</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/26</b> 19 <b>61</b> , and that death occurred at <b>8:15</b> M, from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>John E. Everett</b>		<b>22b. DATE SIGNED</b> <b>MAY 1 '61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>JOHN E. EVERETT</b>		<b>22d. ADDRESS</b> <b>9400 Conn. Ave, Kensington</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>May 1, 1961</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Switzland Md.</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. W. Lee</b>		<b>25. REC'D BY REGISTRAR</b> <b>MAY 1 '61</b>	
<b>25a. ADDRESS</b> <b>300-4 ST NE Wash. D.C.</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kenna</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4539

04529

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>3 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>123 Lexington Drive</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Union</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pine Lake Park</b> d. STREET ADDRESS <b>Box 568 - M</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Anna Mary Nittoli</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>2</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>October 20, 1890</b>
<b>9. AGE</b> (In years last birthday) <b>70 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <b>5</b> Days <b>12</b>	<b>IF UNDER 24 HRS.</b> Hours <b>12</b> Min. <b>12</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Italy</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Peter Araneo</b>		<b>14. MOTHER'S MAIDEN NAME</b> <del>xxxxxxxx</del> <b>Rose Mary</b> <b>unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>	
<b>17. INFORMANT</b> <b>Chester A. Nittoli</b>		<b>Address</b> <b>Box 568 m, Pine Lake Park</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, primary</b> DUE TO (b) <b>left breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 yrs.</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Mar 4 1961</b> <b>to</b> <b>April 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>Mar 31 1961</b> , and that death occurred at <b>143</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>A. L. Thibadeau</b>		<b>22b. DATE SIGNED</b> <b>APR 7 '61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>A. L. Thibadeau</b>		<b>22d. ADDRESS</b> <b>10,111 Colesville Rd. Silver Spring, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>April 6, 1961</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Hollywood Cemetery</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Union County New Jersey</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Raymond A. Jaska</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
COUNTY				a. STATE b. COUNTY			
Montgomery MARYLAND				Maryland Montg			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
Takoma Park		D.O.A.		37 Silver Spring		2622 Newton St	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Washington Sanitarium + Hosp.							
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
GORDON FRANKLIN NOAH				4 9 1961			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
m	w		8-4-06	54 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Carpenter		CONSTRUCTION		N.C. Burlington		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Martin Noah		Viola ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
? NO NONE		577-12-8392		Mrs. A. C. Baird 4411 Tuckerman ST			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) 420.1 DUE TO							
Coronary occlusion							
Conditions, if any, which gave rise to immediate cause (b)							
(a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschert				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. Broschert				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 4-9-61			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
BURIAL		4-11-1961		FORT LINCOLN		BLADENSBURG, MD.	
23. FUNERAL DIRECTOR ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
WWCHAMBERS CO. RIVERDALE, MD				DATE APR 12 '61		Arthur S. Kraus	

04530

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GORDON FRANKLIN WORN

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WILKINSON CO. KILDEARE, MD  
OUTRIG 4-11-MI FORT PINCORN  
BRADENSTONE, MD.

1. **FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04531

1. PLACE OF DEATH COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp. Burnt Mills Hills, MD</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>915 McCENNEY AVENUE</u>			
3. NAME OF DECEASED (Type or print) <u>Bernard</u> First <u>GEORGE</u> Middle <u>Ostmann</u> Last				4. DATE OF DEATH <u>4</u> Month <u>21</u> Day <u>1961</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-15-02</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dudley, Jones, Moroney &amp; Ostmann Co.</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Anton Ostmann</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Nolte</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-38-2252</u>		17. INFORMANT <u>Mrs Irene Ostmann</u> Address <u>Wife. Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Central Vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Found collapsed in bed.</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous C.V.A. about 2 yrs ago</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>April 21-61</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/24/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>APR 25 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

2

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My name

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City of

Mass.

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4542  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04532

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN lb <b>6 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>8712 COLESVILLE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>Robert</b> Last <b>OWEN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1888</b>
9. AGE (In years lost birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min. <b>72</b>	IF UNDER 24 HRS. Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min. <b>72</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent of Public Works (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Service Adm. U.S. Gov't.</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Owen</b>		14. MOTHER'S MAIDEN NAME <b>Emma Mays</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Margaret Ruckert Owen, 8712 Colesville Rd.</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis &amp; left hemiplegia</b> DUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/7 to 4/16</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/16</b> , 19 <b>61</b> and that death occurred at <b>1015 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>William D. Aud</b>		22b. DATE SIGNED <b>4/17/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>		22d. ADDRESS <b>9006 Colesville Rd., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/10/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Jaska</b>		25a. REC'D BY REGISTRAR DATE <b>APR 11 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
DATE: [illegible]  
[The remainder of the document contains several paragraphs of text that are mostly illegible due to extreme fading and bleed-through from the reverse side. Some faint words like "whereas", "and", "that", and "it is the policy" are visible.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

4543

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04533

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>625 W. Lynfield Street</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>625 W. Lynfield St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HUGH M. PARKER</b>		4. DATE OF DEATH <b>April 27, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1889</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tenn.</b>	
11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>John W. Parker</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Clark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Rosa Lee Parker-Item# 2</b>	
17. INFORMANT <b>Rosa Lee Parker-Item# 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of previous heart disease</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/29/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		ADDRESS <b>Funeral Home-1331 E. Montg. Ave. Rockville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 2 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	

NAVY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOWED		DIVORCED		RECEIVED		RECEIVED		RECEIVED	
OCCUPATION		EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		NATIONALITY		CITIZENSHIP		RESIDENCE		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE		WEIGHT		HEIGHT	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY		STATE		COUNTRY		RECEIVED		RECEIVED	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 19 Film G285 4/21/61 iwk

04534

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b <u>8 da.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1325 Coral Sea Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Georgia Alma Parrish</u> First Middle Last		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 29 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Sloter</u>		14. MOTHER'S MAIDEN NAME <u>Edwards</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		17. INFORMANT <u>Stanley E. Parrish, same as above (son)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple pulmonary EMBOLI &amp; INFARCTION 2d</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Rheumatic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1961</u> to <u>4/16/61</u> , that (I) (we) last saw the deceased alive on <u>4/16/61</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur S. Kraus</u>		22b. DATE SIGNED <u>4/17/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur S. Kraus</u>		22d. ADDRESS <u>Rockville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-19-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CHURCH</u>		23d. LOCATION (City, town or county) (State) <u>LANCASTER CO. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>V.W. Lott</u>		25a. REC'D BY REGISTRAR <u>APR 19 61</u>	
ADDRESS <u>3004 ST. N.E.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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11-10-50

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE  
BUREAU OF PUBLIC HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE OF

NEW YORK

County of

City of

State of

Decedent's Name

Age

Sex

Color

Marital Status

Occupation

Education

Religion

Place of Birth

Date of Birth

Place of Death

Time of Death

Cause of Death

Manner of Death

Signature of Examiner

Signature of Coroner

Signature of Physician

Signature of Medical Examiner

Signature of Medical Examiner

Signature of Medical Examiner

Signature of Medical Examiner

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4546

04536

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>D.C.</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>3325 Dix ST. N.E.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ludie Kate Perry</u>				4. DATE OF DEATH Month Day Year <u>April 2 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 10 1926</u> 35 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jack Calloway</u>				14. MOTHER'S MAIDEN NAME <u>Freeman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>				16. SOCIAL SECURITY NO. <u>579-32-6605</u>			
17. INFORMANT <u>James E. Perry, same as above.</u>				Address <u>—</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Breast - metastases to bones, liver and cervical nodes.</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>— 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) ( <u>his</u> hospital) attended the deceased from <u>July 1960</u> to <u>April 2, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 25 1961</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Stanley J. Talper M.D.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 2 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>—</u>				22d. ADDRESS <u>—</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>April 5, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		23d. LOCATION (City, town or county) (State) <u>Bladensburg Rd. N.E.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Thompson</u> ADDRESS <u>Bethesda Md.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanson</u>	

(M)

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1988

1988

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Biology" and "April" are faintly visible.]*

*[Faint handwritten notes at the bottom of the page, including what appears to be a date "April 2nd" and a name "P. Olivet".]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

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MEDICAL  
CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton d. STREET ADDRESS Box 734, RR #1														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN 1b 14 days					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital																			
3. NAME OF DECEASED (Type or print) First Ellis Middle Last PETERS					4. DATE OF DEATH Month April Day 5 Year 1961														
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-1-04		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer					10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy					11. BIRTHPLACE (State or foreign country) Kentucky					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William B. PETERS					14. MOTHER'S MAIDEN NAME Rohda Helen MC GEORGE														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 1923 to 1946					17. INFORMANT (W) Mildred E. Peters, same as #2 above					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intercerebral hemorrhage 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma (c) Auto accident										INTERVAL BETWEEN ONSET AND DEATH 15 days									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto which was struck by another vehicle, Rt. #5					4700 Block									
20c. TIME OF INJURY Month, Day, Year Hour XX. 9:20 p.m. 3-19 1961					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street					20f. (City or town) (County) (State) Silver Hill, Pr. George, Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Broschart					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 4-6-61									
EXAMINER'S NAME (Type) Frank J. BROSCART, M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					Address (Street, city, town, or county) Gaithersburg, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 4-10-61					22c. NAME OF CEMETERY OR CREMATORY Arlington National					22d. LOCATION (City, town, or country) (State) Arlington Virginia				
23. FUNERAL DIRECTOR Simmons Bros.					ADDRESS WashDC					24a. REC'D BY REGISTRAR APR 10 '61					24b. REGISTRAR'S SIGNATURE Arthur L. Hanna				
Simmons Bros. Funeral Home, 1661 Good Hope Rd. SE										DATE									

FOR THE  
DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
4548  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04538

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>12 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Newark</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark</b> d. STREET ADDRESS <b>84 Magazine Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>Walter Henry Paul Peterson</b>				4. DATE OF DEATH Month Day Year <b>April 21 1961</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 7, 1919</b>		9. AGE (In years last birthday) <b>42</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during last year or dates of service) <b>Seaman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Shipping</b>				11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Walter P. Peterson</b>				14. MOTHER'S MAIDEN NAME <b>Janie Hodgkiss</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW II 138-12-7639</b>				17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mitral insufficiency with congestion of the lungs</b> DUE TO (b) <b>insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Rheumatic heart disease, Mitral stenosis and mitral</b> Years												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 9 1961</b> to <b>April 21 1961</b> that (I) (we) last saw the deceased alive on <b>April 21 1961</b> , and that death occurred at <b>1:55 PM</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Roland Folse, MD</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>4/22/61</b>							
22c. PHYSICIAN'S NAME (Type) <b>J. ROLAND FOLSE, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 4-23-61</b>				23b. DATE THEREOF <b>4-23-61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Grove Mem. Park</b>				23d. LOCATION (City, town, or county) (State) <b>Paterson, New Jersey</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 25 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

UNITED STATES OF AMERICA

IN SENATE

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

FOR THE YEAR ENDING JUNE 30, 1901

WASHINGTON: GOVERNMENT PRINTING OFFICE: 1901

341-101-01

1901

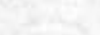
THE COMMISSIONER OF THE GENERAL LAND OFFICE

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

FOR THE YEAR ENDING JUNE 30, 1901

WASHINGTON:

GOVERNMENT PRINTING OFFICE: 1901



DEPARTMENT OF THE INTERIOR

GENERAL LAND OFFICE

WASHINGTON

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1901

U. S. GOVERNMENT PRINTING OFFICE

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

FOR THE YEAR ENDING JUNE 30, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

4549

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04539

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>46 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>3819 Beecher Street, N.W.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Ruby</b> Middle <b>Arlena</b> Last <b>Pippel</b>		4. DATE OF DEATH		Month <b>April</b> Day <b>8</b> Year <b>19 61</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 8, 1920</b>		9. AGE (In years last birthday) <b>40</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Guy Strickland</b>				14. MOTHER'S MAIDEN NAME <b>Lora Wheelus</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septecemia</b> 204 ✓ DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myelogenous Leukemia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive heart failure</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b> <b>2 Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>February 21, 19 61</b> to <b>April 8, 19 61</b> that (I) (we) last saw the deceased alive on <b>April 8, 19 61</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.								
22a. SIGNATURE <b>Edward E. Morse</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>4-8-61</b>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Edwrd E. Morse M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-12-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery, Arlington, Va.</b>		23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J. Gannon</b>				ADDRESS <b>1756 Park Ave. N.W.</b>		25a. REC'D BY REGISTRAR <b>APR 12 '61</b>		
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		

CERTIFICATE OF DEATH

State of Colorado

Washington

No. 1000

1000

On this 10th day of January, 1900, at the City of Denver, Colorado, I, the undersigned, a duly qualified and licensed physician, do hereby certify that

the within and foregoing is a true and correct statement of the facts and circumstances of the death of

John J. Smith, deceased, who died at the age of 45 years, on the 10th day of January, 1900, at the City of Denver, Colorado.

Witness my hand and the seal of my office, this 10th day of January, 1900.

John J. Smith, deceased, who died at the age of 45 years, on the 10th day of January, 1900, at the City of Denver, Colorado.

Witness my hand and the seal of my office, this 10th day of January, 1900.

John J. Smith, deceased, who died at the age of 45 years, on the 10th day of January, 1900, at the City of Denver, Colorado.

Witness my hand and the seal of my office, this 10th day of January, 1900.

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Witness my hand and the seal of my office, this 10th day of January, 1900.

John J. Smith, deceased, who died at the age of 45 years, on the 10th day of January, 1900, at the City of Denver, Colorado.

Witness my hand and the seal of my office, this 10th day of January, 1900.

John J. Smith, deceased, who died at the age of 45 years, on the 10th day of January, 1900, at the City of Denver, Colorado.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4550

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04540

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>98 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>Route # 4, Box 88</b>	
3. NAME OF DECEASED (Type or print) First <b>Elbert</b> Middle <b>Delano</b> Last <b>Porter, Sr.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31, 1938</b>
9. AGE (In years last birthday) <b>22</b> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Agricultural Statistician Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J.R. Porter</b>		14. MOTHER'S MAIDEN NAME <b>Eunice Stevens</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia producing shock</b> DUE TO <b>spread</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chondrosarcoma of right hip with extensive local</b> DUE TO <b>17 months</b> (c) <b>Metastatic chondrosarcoma of lung</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>of right lung</b> <b>Acute &amp; chronic pyelonephritis; partial obstruction sigmoid colon; abscess</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 15, 1961</b> to <b>April 23, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 23, 1961</b> , and that death occurred at <b>7:25AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Martin Nydick</b>		22b. DATE <b>4/23/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARTIN NYDICK, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		23b. DATE THEREOF <b>4/24/61</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>S. Carolina</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
25a. REC'D BY REGISTRAR DATE <b>APR 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinard</b>	

OFFICE OF DEATH

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The following information was received from the

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4551  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04541

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <b>10701 Shaftsbury Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elisha</b> First <b>Pratt</b> Last		4. DATE OF DEATH Month <b>4</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 1, 1902</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sanitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beard Education Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>CIEM PRATT</b>		14. MOTHER'S MAIDEN NAME <b>Florence THORN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 Min app 3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1958</b> to <b>April 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1961</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>George Sharpe</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>George Sharpe M.D.</b>		22d. ADDRESS <b>10511 Summit Ave Kensington, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/11/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial.</b>		23d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert K. Snowden</b>		25a. REC'D BY REGISTRAR <b>Arthur S. Hanna</b>	
ADDRESS <b>Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	
DATE <b>APR 13 '61</b>			

CERTIFICATE OF DEATH

(M)

11/11

may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4552

04542

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>8 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Patricia</b> Middle <b>Dean</b> Last <b>Pringle</b>				4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12 September 1930</b>	
9. AGE (In years last birthday) <b>30</b> yrs.		10. IF UNDER 1 YEAR Months <b>30</b> Days <b>0</b> Hours <b>0</b> Min.		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
11. BIRTHPLACE (State or foreign country) <b>Texas</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Leon LeBlanc</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Nix</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>463-36-5159</b>			
17. INFORMANT <b>The Medical Record, The Clinical Center, Bethesda 14, Maryland</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac hemosiderosis</b> DUE TO (c) <b>Aplastic anemia</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (it) (this hospital) attended the deceased from <b>March 29, 1961</b> , to <b>April 6, 1961</b> , that (it) (we) last saw the deceased alive on <b>April 6, 1961</b> , and that death occurred at <b>1:35 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Leon E. Rosenberg</b>				22b. DATE SIGNED <b>4/6/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Leon E. Rosenberg, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>4-7-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SPRINGTOWN</b>		23d. LOCATION (City, town, or county) (State) <b>SPRINGTOWN TEXAS</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO. 1406 CHAPIN ST.</b>				25a. REC'D BY REGISTRAR <b>APR 10 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>							

MEDICAL CERTIFICATION

325

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained to hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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4553

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04543

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>43 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 X - 2</b> d. STREET ADDRESS <b>2424 Eye Street, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <b>Jean</b> Middle <b>Alfred</b> Last <b>Pulver</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 20, 1899</b>		9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min. <b>62</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>				11. BIRTHPLACE (State or foreign country) <b>Switzerland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Christian Pulver</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Christen</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>033-18-1357</b>				17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic rhabdomyosarcoma</b> DUE TO (c) <b>1977-9</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema</b>												INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>3 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 5</b> 19 <b>61</b> to <b>April 17</b> 19 <b>61</b> , that <del>he</del> (we) last saw the deceased alive on <b>April 17</b> 19 <b>61</b> , and that death occurred at <b>3:35 a.m.</b> from the causes and on the date stated above.																			
22a. SIGNATURE <i>Walter Oppelt</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE <b>4/17/61</b>											
22c. PHYSICIAN'S NAME (Type) <b>WALTER OPPELT, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>				22e. DATE <b>4/17/61</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>4/18/1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION (City, town, or county) (State) <b>Prince Georges Co., Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Hawler's Sons</i>				ADDRESS <b>1756 Pa. Ave. NW WASH, D.C.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 19 '61</b>				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Signature of informant

10. Signature of witness

11. Date of registration

12. Place of registration

13. Signature of registrar

14. Signature of informant

15. Signature of witness

16. Signature of registrar

17. Signature of registrar

18. Signature of informant

19. Signature of witness

20. Signature of registrar

21. Signature of informant

22. Signature of witness

23. Signature of registrar

24. Signature of informant

25. Signature of witness

26. Signature of registrar

27. Signature of informant

28. Signature of witness

29. Signature of registrar

30. Signature of informant

31. Signature of witness

32. Signature of registrar

33. Signature of informant

34. Signature of witness

35. Signature of registrar

36. Signature of informant

37. Signature of witness

38. Signature of registrar

39. Signature of informant

40. Signature of witness

41. Signature of registrar

42. Signature of informant

43. Signature of witness

44. Signature of registrar

45. Signature of informant

46. Signature of witness

47. Signature of registrar

48. Signature of informant

49. Signature of witness

50. Signature of registrar

51. Signature of informant

52. Signature of witness

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MEDICAL CERTIFICATION

22a. SIGNATURE  
J. P. Andrews  
22c. PHYSICIAN'S  
NAME (Type)  
J. P. ANDREWS

22c. PHYSICIAN'S NAME (Type) P. P. ANDREWS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/6/1966

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  
The S.H. Hines Company-2901 14th St., N.W.  
Washington 9, D.C.

☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 4-3-61  
 SS  
 KESSENDEN ST. NW WASH. D.C.

ESSENDEN ST. NW WASH. D.C.

23d. LOCATION (City, town, or county) (State)

Fory Washington, D.C.

25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
APR 4 '61	Arthur L. Frazer

4554

04544

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington,</b>		c. LENGTH OF STAY IN lb <b>24 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		4-78-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3000 McComas Avenue Kensington Gardens Sanitarium</b>		d. STREET ADDRESS <b>3880 Porter Street, N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Terese</b>		First		Middle <b>E. Ramisch</b>		Last	
5. SEX <b>F</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 25, 1881</b>	
9. AGE (In years last birthday) <b>79 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. DATE OF DEATH <b>April 3 1961</b>		12. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Kisler</b>		14. MOTHER'S MAIDEN NAME <b>Julienne Bruckner</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>577-20-4462</b>		17. INFORMANT <b>Kensington Gardens Sanitarium, Kensington, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis with Hypertensive Cerebral Vascular Disease</b> (c) <b>Hypertensive Cerebral Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 hours</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1955</b> to <b>April 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 2, 1961</b> , and that death occurred at <b>5:40 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>F. F. Andrews</b>		22b. DATE SIGNED <b>4-3-61</b>		22c. PHYSICIAN'S NAME (Type) <b>F. F. ANDREWS</b>		22d. ADDRESS <b>4201 FESSENDEN ST. N.W. WASH. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/6/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery Washington D.C.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company-2901 14th St. N.W. Washington 9, D.C.</b>		25a. REC'D BY REGISTRAR <b>APR 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

1000

22

4555

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>				c. LENGTH OF STAY IN 1b <u>X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8704-Brickyard Rd.</u>				d. STREET ADDRESS <u>8704-Brickyard Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>R</u> Last <u>RANDALL</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>7TH</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-6-1877</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Months		Days		Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Peter Little</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hoody</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Best M. Randall 8704-Brickyard Rd.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>20 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>January 10 1942</u> to <u>April 7 1961</u> , that I last saw the deceased alive on <u>April 5 1961</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4-7-61</u> DATE SIGNED <u>John H Hazard</u>							
ACTUAL SIGNATURE <u>John H Hazard</u> M.D. <u>3409 Wisconsin Ave N.W.</u>							
PHYSICIAN'S NAME (Type) <u>John H Hazard</u> <u>Washington D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-10-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. 3072- M. St. N.W.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE APR 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
hours after death. Page 4 must be retained by the hospital or attending physician.  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4556 CERTIFICATE OF DEATH 04546											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>3 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>				d. STREET ADDRESS <u>3503 Woodbine ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens SAN.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>G</u> Last <u>Reith</u>						4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>1961</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/8/1870</u>		9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>William Reith</u>						14. MOTHER'S MAIDEN NAME <u>Mary Rose Caspar</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Sanitarium Records</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AORTIC STENOSIS</u> 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>UNDETERM.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u>		20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>8</u> 1957 to <u>APRIL 20</u> 1961 that (I) (we) last saw the deceased alive on <u>4-20-1961</u> , and that death occurred at <u>11:00 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Stanley M. Silverberg</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-20-61</u>			
22c. PHYSICIAN'S NAME <u>STANLEY M. SILVERBERG, M.D.</u>						22d. ADDRESS <u>1834 CONN. AVE. N.W. WASH. D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/24/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Severs Sons Co</u>						ADDRESS <u>3605-14 St NW</u>		25a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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Memorandum  
to the  
Honorable  
Chairman  
of the  
Committee  
on  
Education  
and  
Labor  
from  
the  
Department  
of  
Education  
and  
Labor  
dated  
June 1, 1914

Subject: *Report of the  
Commissioner of  
Education for the  
Year 1913-1914*

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

MAY 3 1961											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)						c. LENGTH OF STAY IN 1b 11 days					
NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						d. STREET ADDRESS 804 Hamilton Street, N.E.					
3. NAME OF DECEASED (Type or print) First Middle Last Julian Hawthorne RICHARDSON						4. DATE OF DEATH Month Day Year April 29 1961					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3, 1905		9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Virginia				11. BIRTHPLACE (County & State, or foreign country) USA			
13. FATHER'S NAME Nelson RICHARDSON						14. MOTHER'S MAIDEN NAME Susy (Unknown)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII						16. SOCIAL SECURITY NO. 577-07-3157					
17. INFORMANT (W) Mrs. Emma Richardson, same as #2 above						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, squamous cell, larynx DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from April 18, 1961 to April 29, 1961 that (X) (we) last saw the deceased alive on April 29, 1961, and that death occurred at 9:50 AM, from the causes and on the date stated above.											
22a. SIGNATURE T. E. TAYLOR, LT, MC, USN						22b. DATE SIGNED 4-29-61					
22c. PHYSICIAN'S NAME (Type) T. E. TAYLOR, LT, MC, USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-3-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Hall Bros. Undertakers, 621 Florida Ave., N.W.						25a. REC'D BY REGISTRAR DATE MAY 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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I

Mr. Jones (11-1)

U. S. Naval Hospital

Albany

Postoffice

Richmond

Oct. 3, 1902

Virginia

Dear Sir:

Dear Sir:

Yours truly,

Wm. H. Jones, Jr. (11-1) (11-1) (11-1)

Colonel, Richmond, Va.

U. S. Naval Hospital, Richmond, Va.

Richmond, Va.

Richmond, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
ISM 9/59

4558  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04548

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington D.C.</u> COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanatorium</u>		d. STREET ADDRESS <u>15106 New Port Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>F.</u> Middle <u>Riecks</u> Last		4. DATE OF DEATH Month <u>Apr.</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carl Frederick Riecks</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Benjamin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Charles B. Riecks son</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420-1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>-</u> (c) <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>20 years +</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 1, 1950</u> to <u>April 4, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 3, 1961</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Hazard</u>		22b. DATE SIGNED <u>4-4-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Hazard, M.D.</u>		22d. ADDRESS <u>3409 Wisconsin Ave., N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/7/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glennwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>APR 10 '61</u>	
ADDRESS <u>300-4 SINE DC</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	

00772

CERTIFICATE OF DEATH

722

(M)

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## 1

M

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4559

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington (16)</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington (16)</u>	
c. LENGTH OF STAY IN 1b <u>3 1/2 days</u>		d. STREET ADDRESS <u>3911 Langley Court N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Livewood</u> Last <u>Riley</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 7 1887</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u>10</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John E Beale</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Lunsford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Robert Milton Riley (son)</u>		Address <u>78 Border Rock Rd. Levittown, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>Hypertension Cardiovascular disease</u> DUE TO (c) <u>4-20-61</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ischemic Mellitus, Cholelithiasis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>4-20</u> p.m. <u>10</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>April 9</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4-8</u> , 19 <u>61</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>P.P. Andrews</u>		22b. DATE SIGNED <u>4-9-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS</u>		22d. ADDRESS <u>WASHINGTON D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/12/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Res. Wash. Cem</u>		23d. LOCATION (City, town or county) (State) <u>Riggs Rd. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. C. Lunsford</u>		25a. REC'D BY REGISTRAR <u>APR 12 '61</u>	
ADDRESS <u>5109 Wisconsin Ave N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

4560

04550

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM FORSYTH ROBERTSON</b>		4. DATE OF DEATH Month Day Year <b>APRIL 27 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/4/11</b>
9. AGE (In years lost birthday) <b>49 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FINANCE OFFICER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON, D. C.</b>	
13. FATHER'S NAME <b>WILLIAM V. ROBERTSON</b>		14. MOTHER'S MAIDEN NAME <b>JOSEPHINE FORSYTH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>	
17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforated peptic ulcer</b>			
DUE TO (b) <b>duodenum</b>			
DUE TO (c) <b>acute peritonitis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 23, 1961</b> to <b>April 27, 1961</b> , that (I) (we) lost the deceased alive on <b>April 27, 1961</b> , and that death occurred at <b>3:54 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Arthur F. Woodward</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. F. WOODWARD, M. D.</b>		22d. ADDRESS <b>ROCKVILLE, MARYLAND</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/30/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rockville</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave., Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 2 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur F. Woodward</b>			

11-201

CERTIFICATE OF DEATH

11-201



DECEASED

DATE OF DEATH

PLACE

CAUSE

NAME OF DECEASED

AGE

SEX

RELATIONSHIP

DATE

PLACE

CAUSE

AGE

PLACE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04551

4561

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>RFD #5</b>													
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Anna</b> Middle <b>Kane</b> Last <b>ROSS</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>20</b> Year <b>1961</b>													
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>7-6-92</b>		<b>9. AGE</b> (In years last birthday) <b>68</b> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> - - - - -		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Massachusetts</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>									
<b>13. FATHER'S NAME</b> <b>John KANE</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mora DOWNS</b>													
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>033-09-4509 (D)</b>				<b>17. INFORMANT</b> <b>Mrs. Agnes R. Castagliola, same as #2 above</b> Address									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>5 years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>							
<b>21. I certify</b> that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 17, 1961</b> , to <b>April 20, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 20, 1961</b> , and that death occurred at <b>8:10AM</b> , from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <b>J. M. YOUNG, LT, MC, USN</b>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>4-20-61</b>											
<b>22c. PHYSICIAN'S NAME</b> (Type)				<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>													
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial-Shipment</b>		<b>23b. DATE THEREOF</b> <b>4-22-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b>		<b>23d. LOCATION</b> (City, town or county) <b>Lawrence, Massachusetts</b> (State)											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M.R. Etchison &amp; Son</b>				<b>ADDRESS</b> <b>Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>APR 24 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Fries</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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U.S. National Archives and Records Administration

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4562

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04552

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>18 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Hubbard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>72x-2</b> d. STREET ADDRESS <b>2108 Hubbard Youngstown Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Samuel</b> Last <b>Salomon</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1908</b>
9. AGE (In years last birthday) <b>53 yrs.</b>		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto parts</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Salomon</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Hebrank</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>172-09-1439</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>722.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Post-operative Bleeding</b> DUE TO (c) <b>Surgical Replacement of Aortic Valve</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b> <b>24 Hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe Aortic Valve Insufficiency secondary to Rheumatoid Arthritis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 19</b> 19 <b>61</b> , to <b>April 6</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>April 6</b> 19 <b>61</b> , and that death occurred <b>7:50p</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>James L. Talbert</b>		22b. DATE SIGNED <b>4-7-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES L. TALBERT, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/8/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>WEST UNION</b>		23d. LOCATION (City, town, or county) (State) <b>MARYS PA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Chambers Co. 1400 Chapin St NW</b>		25a. REC'D BY REGISTRAR DATE <b>APR 10 '61</b>	
ADDRESS <b>Wash DC</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

11553

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF DECEASED: [illegible]  
SIGNATURE OF WITNESS: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF CLERK: [illegible]  
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

4563

04553

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>1 MONTH</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>GEORGE</b> Last <b>SAMPSON</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/12/1875</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>LEROY SAMPSON</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA WEBB</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>HOSPITAL RECORDS,</b> Address <b>OLNEY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO <b>THROMBOSIS AT CORONARY ARTERY</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. <b>BILATERAL BRONCHOPNEUMONIA BILATERAL</b> (b) <b>420.1</b> (c) <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 26, 1961</b> to <b>April 25, 1961</b> , that (I) <b>last</b> saw the deceased alive on <b>April 25, 1961</b> , and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Arthur F. Woodward</b>		22b. DATE SIGNED <b>4/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. A. F. WOODWARD</b>		22d. ADDRESS <b>ROCKVILLE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-29-61 Rose Land Cem</b>		23b. DATE THEREOF <b>4-29-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Reedville, Va.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAY 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krasa</b>		25c. DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4564 CERTIFICATE OF DEATH 04554											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>--</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>					
c. LENGTH OF STAY IN 1b <b>3 days</b>						d. STREET ADDRESS <b>3416 Rittenhouse St. N.W.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Dorothy S. Schermerhorn</b>						4. DATE OF DEATH <b>April 15 1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/5/94</b>		9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Denver, Col.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Russell Holman Snead</b>						14. MOTHER'S MAIDEN NAME <b>Mamie Smith 1673</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>						16. SOCIAL SECURITY NO. <b>?</b>					
17. INFORMANT <b>Mrs. Geo. Giguere (Sister)</b>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute MYOCARDIAL INFARCTION</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ARTERIO SCLEROTIC C.V. DISEASE</b>						DUE TO <b>YEARS</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>19:50 APR 15 1961</b> to <b>APRIL 15, 1961</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>APR 15 1961</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>DeWitt E. DeLawter</b> M.D.						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>DeWitt E. DeLawter</b>						22d. ADDRESS <b>3848 Porter Street, N.W.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/18/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Prince Georges County, Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b>						25a. REC'D BY REGISTRAR <b>APR 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			
ADDRESS <b>2901 14th St., N.W. Washington 9, D.C.</b>											

MEDICAL CERTIFICATION

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Ed

Deliveries Apr. 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4565 Item 9 Film G285 4/24/61 iwk 04555											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. + Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u> d. STREET ADDRESS <u>908 Davis Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Henry</u> First <u>Franz</u> Middle <u>Schubert</u> Last						4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1961</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-14-68</u>		9. AGE (in years last birthday) <u>92 1/2</u> yrs.		IF UNDER 1 YEAR Months <u>14</u> Days <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ministry</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Minister</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
13. FATHER'S NAME <u>?</u>						14. MOTHER'S MAIDEN NAME <u>Graf</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (no), or unknown) <input checked="" type="checkbox"/>						16. SOCIAL SECURITY NO. <u>Washington San. + Hosp. Tak. Park Md.</u>					
17. INFORMANT <u>Washington San. + Hosp. Tak. Park Md.</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Congestive heart failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-26-</u> <u>1961</u> , to <u>4-14-</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>4-14-</u> <u>1961</u> , and that death occurred at <u>4:10pm</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Aldo Vacca</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>4-14-61</u> 22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Aldo VACCA</u>						22d. ADDRESS <u>1429 University Blvd, W. Silver Spring</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>April 18-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) <u>Bedfordburg Road N.E. D.C.</u> (State) <u>D.C.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hines</u> ADDRESS <u>254 Carroll St. N.W. Wash. D.C.</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			
						DATE <u>APR 19 '61</u>					

(M)

(1)

Tuberculosis

Hypertension, Generalized

Miss Miller

Miss Miller

X

Miss Miller

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

04556

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakhaven Convalescent Home - 517 Albany Avenue</u>				d. STREET ADDRESS <u>9328 Wilmer Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>R</u> Last <u>Schutt</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 22, 1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George Frye</u>				14. MOTHER'S MAIDEN NAME <u>Clara Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs Evelyn Smith</u> Address <u>9328 Wilmer St. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis</u> DUE TO <u>Coronary thrombosis of a long duration</u> (b) <u>Intercurrent infection</u> DUE TO <u>Intercurrent infection</u> (c) <u>Probable severe anemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Intercurrent infection</u> (b) <u>Intercurrent infection</u> (c) <u>Intercurrent infection</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/20/1961</u> to <u>4/24/1961</u> , that (I) (we) last saw the deceased alive on <u>4/23/1961</u> , and that death occurred at <u>1534</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>H. H. Wolotton, M.D.</u>				22b. DATE SIGNED <u>APR 25 '61</u>			
22c. PHYSICIAN'S NAME (Type) <u>H. H. Wolotton</u>				22d. ADDRESS <u>300 Underwood St NW Wash DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/27/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. H. Hines Co.</u>				25a. REC'D BY REGISTRAR <u>2901-144 St. N.W.</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>				25c. DATE <u>APR 25 '61</u>			

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UNITED STATES OF AMERICA

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4567

CERTIFICATE OF DEATH

Reg. Dist. No. 04557

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. LENGTH OF STAY IN 1b <b>18</b> <b>Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10201 Darnestown Road</b>				d. STREET ADDRESS <b>10201 Darnestown Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>ALBERT T. SCHWARTZBECK</b> First Middle Last				4. DATE OF DEATH <b>April 26,</b> 19 <b>61</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>4/28/1900</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Edward T. Schwartzbeck</b>				14. MOTHER'S MAIDEN NAME <b>Susan J. Kelly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address <b>C. Raymond Schwartzbeck - Item # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure</b> <b>151x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>carcinomatosis</b> DUE TO (c) <b>carcinoma of stomach</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 min.</b> <b>6 min.</b> <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/1/1961</b> to <b>4/26/1961</b> , that I last saw the deceased alive on <b>4/24/1961</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stephen M. Jones</b>		M.D.		ADDRESS (Street, city or town, state) <b>Rockville, Md</b>		DATE SIGNED <b>4/28/61</b>	
PHYSICIAN'S NAME (Type) <b>Stephen Jones - Rockville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/29/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> ADDRESS <b>Funeral Home-1331 E. Montg. Ave</b> <b>Rockville, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 2 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Rands</b>	

5751



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 11m G285 4/21/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

04558

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanatorium</u>		d. STREET ADDRESS <u>09X-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARJORIE ANN SEEDERS</u>		4. DATE OF DEATH Month Day Year <u>APRIL 15 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 June 1912</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer Bullock</u>		14. MOTHER'S MAIDEN NAME <u>Mabel Philpot</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hosp Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Sclerosis</u> (c) <u>Arteriosclerosis - Medial</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>typ</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/21/61</u> , 19 <u>61</u> , to <u>4/1/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/1/61</u> , 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Samuel Allen M.D.</u>		M.D. <u>4/1/61</u>	
PHYSICIAN'S NAME (Type) <u>Allen (SAM)</u>		SAMPLER ALLEN, M.D. Kensington Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-16-61</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Kensington</u>	22d. LOCATION (City, town, or county) (State) <u>Kensington Del</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u>		ADDRESS <u>4812 La Crosse</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

## CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John D. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>65</i>		4. DATE OF BIRTH <i>Jan 15 1895</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1915</i>	
9. NAME OF SPOUSE <i>John D. Smith</i>		10. DATE OF DEATH <i>Dec 10 1960</i>	
11. TIME OF DEATH <i>10:15 AM</i>		12. PLACE OF DEATH <i>Home</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MANNER OF DEATH <i>Natural</i>	
15. SIGNATURE OF PHYSICIAN <i>John D. Smith</i>		16. SIGNATURE OF DECEASED <i>John D. Smith</i>	
17. SIGNATURE OF WITNESS <i>John D. Smith</i>		18. SIGNATURE OF DECEASED <i>John D. Smith</i>	
19. SIGNATURE OF DECEASED <i>John D. Smith</i>		20. SIGNATURE OF DECEASED <i>John D. Smith</i>	
21. SIGNATURE OF DECEASED <i>John D. Smith</i>		22. SIGNATURE OF DECEASED <i>John D. Smith</i>	
23. SIGNATURE OF DECEASED <i>John D. Smith</i>		24. SIGNATURE OF DECEASED <i>John D. Smith</i>	
25. SIGNATURE OF DECEASED <i>John D. Smith</i>		26. SIGNATURE OF DECEASED <i>John D. Smith</i>	
27. SIGNATURE OF DECEASED <i>John D. Smith</i>		28. SIGNATURE OF DECEASED <i>John D. Smith</i>	
29. SIGNATURE OF DECEASED <i>John D. Smith</i>		30. SIGNATURE OF DECEASED <i>John D. Smith</i>	
31. SIGNATURE OF DECEASED <i>John D. Smith</i>		32. SIGNATURE OF DECEASED <i>John D. Smith</i>	
33. SIGNATURE OF DECEASED <i>John D. Smith</i>		34. SIGNATURE OF DECEASED <i>John D. Smith</i>	
35. SIGNATURE OF DECEASED <i>John D. Smith</i>		36. SIGNATURE OF DECEASED <i>John D. Smith</i>	
37. SIGNATURE OF DECEASED <i>John D. Smith</i>		38. SIGNATURE OF DECEASED <i>John D. Smith</i>	
39. SIGNATURE OF DECEASED <i>John D. Smith</i>		40. SIGNATURE OF DECEASED <i>John D. Smith</i>	
41. SIGNATURE OF DECEASED <i>John D. Smith</i>		42. SIGNATURE OF DECEASED <i>John D. Smith</i>	
43. SIGNATURE OF DECEASED <i>John D. Smith</i>		44. SIGNATURE OF DECEASED <i>John D. Smith</i>	
45. SIGNATURE OF DECEASED <i>John D. Smith</i>		46. SIGNATURE OF DECEASED <i>John D. Smith</i>	
47. SIGNATURE OF DECEASED <i>John D. Smith</i>		48. SIGNATURE OF DECEASED <i>John D. Smith</i>	
49. SIGNATURE OF DECEASED <i>John D. Smith</i>		50. SIGNATURE OF DECEASED <i>John D. Smith</i>	
51. SIGNATURE OF DECEASED <i>John D. Smith</i>		52. SIGNATURE OF DECEASED <i>John D. Smith</i>	
53. SIGNATURE OF DECEASED <i>John D. Smith</i>		54. SIGNATURE OF DECEASED <i>John D. Smith</i>	
55. SIGNATURE OF DECEASED <i>John D. Smith</i>		56. SIGNATURE OF DECEASED <i>John D. Smith</i>	
57. SIGNATURE OF DECEASED <i>John D. Smith</i>		58. SIGNATURE OF DECEASED <i>John D. Smith</i>	
59. SIGNATURE OF DECEASED <i>John D. Smith</i>		60. SIGNATURE OF DECEASED <i>John D. Smith</i>	
61. SIGNATURE OF DECEASED <i>John D. Smith</i>		62. SIGNATURE OF DECEASED <i>John D. Smith</i>	
63. SIGNATURE OF DECEASED <i>John D. Smith</i>		64. SIGNATURE OF DECEASED <i>John D. Smith</i>	
65. SIGNATURE OF DECEASED <i>John D. Smith</i>		66. SIGNATURE OF DECEASED <i>John D. Smith</i>	
67. SIGNATURE OF DECEASED <i>John D. Smith</i>		68. SIGNATURE OF DECEASED <i>John D. Smith</i>	
69. SIGNATURE OF DECEASED <i>John D. Smith</i>		70. SIGNATURE OF DECEASED <i>John D. Smith</i>	
71. SIGNATURE OF DECEASED <i>John D. Smith</i>		72. SIGNATURE OF DECEASED <i>John D. Smith</i>	
73. SIGNATURE OF DECEASED <i>John D. Smith</i>		74. SIGNATURE OF DECEASED <i>John D. Smith</i>	
75. SIGNATURE OF DECEASED <i>John D. Smith</i>		76. SIGNATURE OF DECEASED <i>John D. Smith</i>	
77. SIGNATURE OF DECEASED <i>John D. Smith</i>		78. SIGNATURE OF DECEASED <i>John D. Smith</i>	
79. SIGNATURE OF DECEASED <i>John D. Smith</i>		80. SIGNATURE OF DECEASED <i>John D. Smith</i>	
81. SIGNATURE OF DECEASED <i>John D. Smith</i>		82. SIGNATURE OF DECEASED <i>John D. Smith</i>	
83. SIGNATURE OF DECEASED <i>John D. Smith</i>		84. SIGNATURE OF DECEASED <i>John D. Smith</i>	
85. SIGNATURE OF DECEASED <i>John D. Smith</i>		86. SIGNATURE OF DECEASED <i>John D. Smith</i>	
87. SIGNATURE OF DECEASED <i>John D. Smith</i>		88. SIGNATURE OF DECEASED <i>John D. Smith</i>	
89. SIGNATURE OF DECEASED <i>John D. Smith</i>		90. SIGNATURE OF DECEASED <i>John D. Smith</i>	
91. SIGNATURE OF DECEASED <i>John D. Smith</i>		92. SIGNATURE OF DECEASED <i>John D. Smith</i>	
93. SIGNATURE OF DECEASED <i>John D. Smith</i>		94. SIGNATURE OF DECEASED <i>John D. Smith</i>	
95. SIGNATURE OF DECEASED <i>John D. Smith</i>		96. SIGNATURE OF DECEASED <i>John D. Smith</i>	
97. SIGNATURE OF DECEASED <i>John D. Smith</i>		98. SIGNATURE OF DECEASED <i>John D. Smith</i>	
99. SIGNATURE OF DECEASED <i>John D. Smith</i>		100. SIGNATURE OF DECEASED <i>John D. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4569

CERTIFICATE OF DEATH

04559

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. LENGTH OF STAY IN 1b 47 days		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Pennsylvania		f. COUNTY Carlisle	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		3. NAME OF DECEASED (Type or print) Glenn Orville SEIDER		4. DATE OF DEATH April 26 19 61		5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-4-01		9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		11. BIRTHPLACE (County & State, or foreign country) Ohio	
13. FATHER'S NAME Charles SEIDER		14. MOTHER'S MAIDEN NAME Margaret TOOLEY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1921 to 1951 161-32-5048		17. INFORMANT (W) Mrs. Alice D. Seider, same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal aortic aneurysm with rupture DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington		(County) Virginia	
21. I certify that (X) (this hospital) attended the deceased from March 10, 19 61 to April 26, 19 61 that (X) (we) last saw the deceased alive on April 26, 19 61, and that death occurred at 11:15 PM, from the causes and on the date stated above.		22a. SIGNATURE K. V. Harshman M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-27-61		22c. PHYSICIAN'S NAME (Type) K. V. HARSHMAN, LT, MC, USN	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-1-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington		(State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Lutz Hoffman Funeral Home		ADDRESS 219 N. Howard St. Baltimore, Md.		25a. REC'D BY REGISTRAR DATE MAY 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kinas			

M

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RECEIVED (10-1)

U. S. Naval Hospital

GROUP

U. S. Naval Hospital

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U. S. Naval Hospital

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U. S. Naval Hospital

U. S. Naval Hospital, Bethesda, Md.

U. S. Naval Hospital, Bethesda, Md.

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U. S. Naval Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

4580  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4580  
CERTIFICATE OF DEATH  
04560

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X GAITHERSBURG</b> 8. STREET ADDRESS <b>RT. 3 Box 179</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLE ARTHUR SHIRLEY</b>				4. DATE OF DEATH <b>10 PM April 15 1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>MARCH 27 1912</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>odd jobs</b>		11. BIRTHPLACE (County & State, or foreign country) <b>(MONTGOMERY) DARNESTOWN MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES HENRY SHIRLEY</b>				14. MOTHER'S MAIDEN NAME <b>CORA JOHNSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-01-9081</b>		17. INFORMANT <b>MRS. STELLA BIGGUS, RT. 2, DICKERSON MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Active pulmonary tuberculosis</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Unknown</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 15 1961</b> , to <b>April 15 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>April 15 1961</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Allen J. Neill</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>8601 Old Georgetown Road, Bethesda 14 Maryland</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-19-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove, Rockville Md</b>		23d. LOCATION (City, town or county) (State) <b>Poplar Grove, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robt. H. Snowsen</b>				ADDRESS <b>Rockville Md</b>		25a. REC'D BY REGISTRAR DATE <b>APR 20 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

11/20/21

(M)

(I)

Robert S. G. 2 November  
Rockville, MD  
Clemens Hill  
801 1st St. N.E. Washington, D.C.  
18 November 1921

1 ~~2~~  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

371  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04561

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San &amp; Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G. - ✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>8231 - 14th Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Morris (M<sup>th</sup>) Sirmai</u>		4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-1892</u>		9. AGE (In years last birthday) <u>68</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machineist (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>			
13. FATHER'S NAME <u>Samuel Sirmai</u>		14. MOTHER'S MAIDEN NAME <u>Teresa - (UNKNOWN)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>476-01-2457</u>		17. INFORMANT <u>ALBERT SIRMAI</u> Address <u>1111 ARL. BLVD. ARL. VA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive myocardial septal infarct with mural thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Severe coronary atherosclerosis with recent coronary thrombosis.</u> (c) <u>Post op. status (22 days) from suprapubic proctectomy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>5-8 days</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Apr. 18-1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/19/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>G.W. Lew</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md</u>			
23. FUNERAL DIRECTOR <u>Goelberg Funeral Home - 4217-9</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 20 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>		

MEDICAL CERTIFICATION

11-504

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICS AND RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

P. 6

(M)

(I)

Examinee a general medical examination  
reveals coronary atherosclerosis with recent  
myocardial infarction.  
No other significant findings.

Signature of Medical Examiner  
Date of Examination  
Signature of Coroner  
Date of Death

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4572 CERTIFICATE OF DEATH 04562											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5814 Ogden Court</b>						d. STREET ADDRESS <b>5814 Ogden Court</b>					
3. NAME OF DECEASED (Type or print) <b>LARS ARNOLD SITES</b>						4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 20, 1960</b>		9. AGE (In years last birthday) yrs. <b>5</b> Months <b>17</b> Days <b>17</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>						12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>					
13. FATHER'S NAME <b>James Neil Sites</b>						14. MOTHER'S MAIDEN NAME <b>Inger Krogh</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>father</b>						Address <b>Same as Item #2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>3254</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Respiratory Obstruction (mucous)</b> (c) <b>Mongoloid and malnutrition</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>2 hrs.</b> <b>since Birth</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 20, 1961</b> to <b>April 7, 1961</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>March 23, 1961</b> , and that death occurred at <b>3 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Frank Y. Jagers Jr.</b> M.D.						22b. DATE <b>4-7-61</b> SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>FRANK Y. JAGGERS, JR.</b>						22d. ADDRESS <b>5707 Wisconsin Ave., Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>						23b. DATE THEREOF <b>4-8-61</b>					
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>						23d. LOCATION (City, town or county) (State) <b>Prince George County, Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>						25a. REC'D BY REGISTRAR DATE <b>APR 12 '61</b>					
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>											

9VVVVVVV XVV

VR A15 (4)  
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FRANK Y. JAGGERS, JR.

DR.

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Wisconsin Ave., Beasda, R.

Oratorion 4-8-61

Georg Hill Veterinary

Prince George County, Md.

ROBERT A. PUMPHREY

Beasda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4573

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04563

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>WASH.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>3 days 8 hrs</b>		d. STREET ADDRESS <b>3008 McKinley Street, N.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>B</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>4</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28th, 1871</b>
9. AGE (In years last birthday) <b>89</b>		10. IF UNDER 1 YEAR: Months <b>5</b> Days <b>13</b>	
11. IF UNDER 24 HRS. Hours <b>13</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Parking Garage</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes-Unknown</b>	
17. INFORMANT <b>George W. Weigold - 3008 McKinley St. NW- DC</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral, acute peritonitis</b> 540.1 DUE TO <b>post OR - closure perforated</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>peptic ulcer</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/8</b> 19 <b>61</b> to <b>4/11</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>4/11</b> 19 <b>61</b> , and that death occurred at <b>4:45 P.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>R.C. Myers</b>	
22c. PHYSICIAN'S NAME (Type) <b>R.C. Myers</b>		22b. DATE SIGNED <b>4/11/61</b>	
22d. ADDRESS <b>8512 Old Georgetown Rd. Bethesda Md.</b>		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 4/15/61</b>		23b. DATE THEREOF <b>4/15/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chester Rual Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Chester, Pennsylvania</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>DATE APR 13 '61</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kious</b>	

1273

STATE OF OHIO

D. C.

Washington

Department of the Interior

General Land Office

Division of Land Management

Office of the Chief of Survey

Washington, D. C.

June 1, 1908

Very respectfully,

W. A. R. R.

Chief of Survey

Division of Land Management

General Land Office

Washington, D. C.

Enclosed for the Chief of Survey

are the following reports

of the Surveyors

of the Division of Land Management

for the year 1907

Very respectfully,

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4574

04564

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7005 East Avenue</b>		d. STREET ADDRESS <b>7005 East Avenue</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>James Crystal Smith</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>11</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>July 14, 1909</b>
<b>9. AGE</b> (In years last birthday) <b>51</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>8</b> Days <b>27</b> Hours <b>Min.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Fireman</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Tennessee</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Amzi Smith</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mildred Crystal</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>WW 1</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>	
<b>17. INFORMANT</b> <b>Paula H. Smith-Wife-same 2d</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart Disease</b> (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 hr</b> <b>Chloroform</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>5/1</b> <b>1954</b> <b>to</b> <b>4/11</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>4/10</b> <b>1961</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>George Sharpe</b>		<b>22b. DATE SIGNED</b> <b>4/11/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>George Sharpe</b>		<b>22d. ADDRESS</b> <b>10511 Summit Ave Kensington Md</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Cremation</b>		<b>23b. DATE THEREOF</b> <b>4/11/61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Crematory</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Suitland, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey,</b>		<b>25a. REC'D BY REGISTRAR</b> <b>APR 13 '61</b>	
<b>ADDRESS</b> <b>Bethesda, Maryland</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hanna</b>	

VR A15 (4)  
15M 9/60

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Robert A. Rummery, Bethesda, Maryland, 28, 12, 41  
Cotton Hill Laboratory, Suitland, Maryland

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MONTGOMERY  
BETHESDA  
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NEVER MARRIED  
WIDOWED  
HOUSEWIFE-RETAILER  
PRIVATE  
Z. T. DILLON  
NO  
579-23-47  
HENRY B. PARIS, as above.  
420-1  
DUE TO  
CONDITIONS, IF ANY, WHICH  
GAVE RISE TO IMMEDIATE CAUSE  
(a), stating the underlying  
cause last.  
DUE TO  
HYPERTENSIVE ARTERIO-SCLEROTIC CARDIO-  
VASCULAR DISEASE  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
2Da. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)  
20c. TIME OF INJURY  
Month, Day, Year  
Hour a.m.  
p.m.  
19  
2Dd. INJURY OCCURRED  
While at work  
Not While at work  
2De. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)  
20f. (City or town)  
(County)  
(State)  
21. I certify that (I) (this hospital) attended the deceased from 4-17 to 4-19, 1961, that (I) (we) last saw the deceased alive on 4-19, 1961, and that death occurred at 8:15 P.M. from the causes and on the date stated above.  
22a. SIGNATURE  
Edward W. Youngblood M.D.  
22c. PHYSICIAN'S NAME (Type)  
Edward W. Youngblood  
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐  
22d. ADDRESS  
Washington Clinic- D. C.  
23a. BURIAL, CREMATION, REMOVAL (Specify)  
Removal  
23b. DATE THEREOF  
4/20/61  
23c. NAME OF CEMETERY OR CREMATORY  
Spring Hill Cemetery  
23d. LOCATION (City, town or county)  
(State)  
Huntington, West Virginia  
24. FUNERAL DIRECTOR'S SIGNATURE  
The S. H. Hines Co.  
ADDRESS  
Washington, D. C.  
25a. REC'D BY REGISTRAR  
25b. REGISTRAR'S SIGNATURE  
APR 21 '61  
C. L. H. Hines

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 2da.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4330 Yuma St. N.W. d. STREET ADDRESS 4330 Yuma St. N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Dillon Spider 4. SEX F 5. COLOR OR RACE W 6. MARIED NEVER MARRIED WIDOWED DIVORCED 7. DATE OF BIRTH 9-9-79 8. AGE (In years last birthday) 81 yrs. 9. IF UNDER 1 YEAR Months Days 10. IF UNDER 24 HRS. Hours Min.		11. BIRTHPLACE (County & State, or foreign country) West Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Z. T. Dillon 14. MOTHER'S MAIDEN NAME Tennessee Haynie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 16. SOCIAL SECURITY NO. 579-23-47 17. INFORMANT Henry B. Paris, as above.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO HYPERTENSIVE ARTERIO-SCLEROTIC CARDIO- VASCULAR DISEASE INTERVAL BETWEEN ONSET AND DEATH 9 days unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4-17 to 4-19, 1961, that (I) (we) last saw the deceased alive on 4-19, 1961, and that death occurred at 8:15 P.M. from the causes and on the date stated above.	
22a. SIGNATURE Edward W. Youngblood M.D. 22c. PHYSICIAN'S NAME (Type) Edward W. Youngblood		22b. DATE APR 21 '61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE THEREOF 4/20/61 23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery 23d. LOCATION (City, town or county) (State) Huntington, West Virginia		24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. ADDRESS Washington, D. C. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE C. L. H. Hines	

The S. H. Lines Co., Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4576

04566

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>38 Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>13208 Ferndale Street</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ida</u> Middle <u>J.</u> Last <u>Spille</u>		<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 16, 1882</u>
9. AGE (in years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>
13. FATHER'S NAME <u>William Wilke</u>		14. MOTHER'S MAIDEN NAME <u>Matilda (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT (Name & Address) <u>Wilmer P. Scheer (same as above)</u>
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>540.0 Acute peritonitis</u> DUE TO (b) <u>Separation of Anastomoses</u> DUE TO (c) <u>Gastric Resection for Bleeding duodenal Ulcer</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 d</u> <u>10 d</u> <u>10 d</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 21, 1961</u> to <u>4/4/61</u> , that (I) <u>we</u> last saw the deceased alive on <u>3/29/61</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Horace W. Bernton, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/4/61</u>
22c. PHYSICIAN'S NAME (Type) <u>Horace W. Bernton, M.D.</u>		22d. ADDRESS <u>4743 Bradley Blvd (Phthis) Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 4/4/61</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>Port Wash. Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Port Washington, Wisconsin</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25. REC'D BY REGISTRAR <u>APR 6 '61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

(M)

(1)

HOUSEWIFE

(Hollow)

None

No

Little per... ..

Separation of ... ..

Separation of ... ..

Notes: 1. Burton, M.D.

Burial-transit A/V of Port Wash. Cemetery Port Washington, Wisconsin

Robert A. Bughrey Bethesda, Maryland

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

4577  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04567

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tarom Park</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash Saint Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Josephine Kenville Stallone</u>				4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-86</u>	9. AGE (In years and birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS Anita Gamble</u> Address <u>Same as deceased</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-11-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>APRIL 14, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CHURCH CEM.</u>	
23. FUNERAL DIRECTOR <u>Arthur S. Kraw</u>				22d. LOCATION (City, town, or country) <u>ACCOKEEK, Md.</u>			
ADDRESS <u>254 Garrold St. N.W. D.C.</u>				24a. REC'D BY REGISTRAR <u>APR 13 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

MEDICAL CERTIFICATION

FOR THE  
MEDICAL

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THE  
MEDICAL  
OFFICE  
OF THE  
ARMY  
AND  
NAVY  
DEPARTMENT  
WASHINGTON  
D. C.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4578

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04568

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C. Md.</b> b. COUNTY <b>Mont.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>D, O, A</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 16</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>5807 Devonshire Road Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>E</b> Last <b>Stephens</b>				4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 14 1896</b>	
9. AGE (In years lost birthday) <b>64</b>		10. AGE (In years lost birthday) <b>64</b>		11. BIRTHPLACE (State or foreign country) <b>Memphis. Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>William Stephens</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>578-32-6242</b>		17. INFORMANT <b>Mrs. Alfred Malboruf (Daughter)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Septal myocardial infarct on 9 April 61</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10 April 1961</b> to <b>29 Apr 1961</b> , that (I) (we) last saw the deceased alive on <b>27 Apr 1961</b> and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Herbert Martyn Jr.</b>				22b. DATE <b>29 Apr 61</b>		22c. PHYSICIAN'S NAME (Type) <b>Herbert Martyn Jr.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>5/1/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	
23d. LOCATION (City, town, or county) <b>Suitland, Maryland</b>				23e. REC'D BY REGISTRAR DATE <b>MAY 3 '61</b>			
23f. REGISTRAR'S SIGNATURE <b>Arthur S. Krawe</b>				23g. REGISTRAR'S SIGNATURE <b>Arthur S. Krawe</b>			

24. FUNERAL DIRECTOR'S SIGNATURE  
**Robert A. Humphrey** ADDRESS  
**Bethesda, Maryland**

**C. H. Humphrey Funeral Homes**

0150

UNITED STATES DEPARTMENT OF HEALTH  
CENTRAL CASE OF 1940

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1. Name of patient: [illegible]  
2. Date of birth: [illegible]  
3. Sex: [illegible]  
4. Race: [illegible]  
5. Religion: [illegible]  
6. Education: [illegible]  
7. Occupation: [illegible]  
8. Address: [illegible]  
9. City: [illegible]  
10. State: [illegible]  
11. Zip: [illegible]  
12. Date of admission: [illegible]  
13. Date of discharge: [illegible]  
14. Date of death: [illegible]  
15. Cause of death: [illegible]  
16. Place of death: [illegible]  
17. Date of autopsy: [illegible]  
18. Name of pathologist: [illegible]  
19. Name of physician: [illegible]  
20. Name of hospital: [illegible]  
21. Name of clinic: [illegible]  
22. Name of laboratory: [illegible]  
23. Name of pharmacy: [illegible]  
24. Name of dentist: [illegible]  
25. Name of nurse: [illegible]  
26. Name of dietitian: [illegible]  
27. Name of pharmacist: [illegible]  
28. Name of technician: [illegible]  
29. Name of assistant: [illegible]  
30. Name of clerk: [illegible]  
31. Name of janitor: [illegible]  
32. Name of porter: [illegible]  
33. Name of cook: [illegible]  
34. Name of cleaner: [illegible]  
35. Name of gardener: [illegible]  
36. Name of driver: [illegible]  
37. Name of messenger: [illegible]  
38. Name of interpreter: [illegible]  
39. Name of translator: [illegible]  
40. Name of stenographer: [illegible]  
41. Name of typewriter: [illegible]  
42. Name of calculator: [illegible]  
43. Name of recorder: [illegible]  
44. Name of operator: [illegible]  
45. Name of engineer: [illegible]  
46. Name of electrician: [illegible]  
47. Name of plumber: [illegible]  
48. Name of carpenter: [illegible]  
49. Name of painter: [illegible]  
50. Name of mason: [illegible]  
51. Name of bricklayer: [illegible]  
52. Name of roofer: [illegible]  
53. Name of joiner: [illegible]  
54. Name of cooper: [illegible]  
55. Name of blacksmith: [illegible]  
56. Name of farrier: [illegible]  
57. Name of veterinarian: [illegible]  
58. Name of farmer: [illegible]  
59. Name of ranchman: [illegible]  
60. Name of hunter: [illegible]  
61. Name of fisherman: [illegible]  
62. Name of logger: [illegible]  
63. Name of miner: [illegible]  
64. Name of oil worker: [illegible]  
65. Name of coal miner: [illegible]  
66. Name of steel worker: [illegible]  
67. Name of automobile worker: [illegible]  
68. Name of airplane worker: [illegible]  
69. Name of ship worker: [illegible]  
70. Name of aircraft worker: [illegible]  
71. Name of rocket worker: [illegible]  
72. Name of satellite worker: [illegible]  
73. Name of computer worker: [illegible]  
74. Name of television worker: [illegible]  
75. Name of radio worker: [illegible]  
76. Name of newspaper worker: [illegible]  
77. Name of magazine worker: [illegible]  
78. Name of book worker: [illegible]  
79. Name of record worker: [illegible]  
80. Name of film worker: [illegible]  
81. Name of photograph worker: [illegible]  
82. Name of painting worker: [illegible]  
83. Name of sculpture worker: [illegible]  
84. Name of jewelry worker: [illegible]  
85. Name of clothing worker: [illegible]  
86. Name of food worker: [illegible]  
87. Name of drink worker: [illegible]  
88. Name of tobacco worker: [illegible]  
89. Name of drug worker: [illegible]  
90. Name of medicine worker: [illegible]  
91. Name of health worker: [illegible]  
92. Name of social worker: [illegible]  
93. Name of teacher: [illegible]  
94. Name of student: [illegible]  
95. Name of professor: [illegible]  
96. Name of researcher: [illegible]  
97. Name of scientist: [illegible]  
98. Name of inventor: [illegible]  
99. Name of discoverer: [illegible]  
100. Name of creator: [illegible]

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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4579  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04569

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Greenville</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>19 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		d. STREET ADDRESS <b>20 McDade Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Levis</b> Middle <b>Odell</b> Last <b>Stone</b>		4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1907</b>
9. AGE (In years lost birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Stone</b>		14. MOTHER'S MAIDEN NAME <b>Belle Woodall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>247-01-1150</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>National Institutes of Health, Bethesda 14, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Open Heart Surgery</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic Heart Disease with Aortic Stenosis</b> DUE TO (c) <b>Arterioneophiosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 9, 19 61</b> to <b>April 28, 19 61</b> , that (I) (we) last saw the deceased alive on <b>April 28, 19 61</b> and that death occurred at <b>12:40PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Benson R. Wilcox</b>		22b. DATE SIGNED <b>4-28-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Benson R. Wilcox M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 4-29-61</b>		23b. DATE THEREOF <b>4-29-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Graceland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Greenville, South Carolina</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 3 '61</b>	
ADDRESS <b>Bethesda, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

CERTIFICATE OF DEATH

1937

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4580

## CERTIFICATE OF DEATH

Reg. Dist. No.

04570

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Silver Spring, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8031-Eastern Avenue, S.S., Md.</b>		d. STREET ADDRESS <b>8031-Eastern Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JEANNETTE P. STRANLEY</b>		4. DATE OF DEATH Month Day Year <b>APRIL 25, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1882</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <b>3 18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hudson Pettit</b>		14. MOTHER'S MAIDEN NAME <b>Mary Pettit.....</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No -----</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Joseph H. Stranley</b>		Address <b>4916-Leisure Drive, Temple Hills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Toxic</b> <b>153-8</b> DUE TO <b>Carcinoma Colon (Revised Oct 1960)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 Oct</b> , 19 <b>60</b> , to <b>24 Apr</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>22 Apr</b> , 19 <b>61</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Thomas P. Fogarty, M.D. 1011 Univ. Blvd S Silver Spring Md 25 April</b>			
ACTUAL SIGNATURE <b>Thomas P. Fogarty</b>			
PHYSICIAN'S NAME (Type) <b>Thomas P. Fogarty, 1011-University Blvd., Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/28/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HYSOYNG'S FUNERAL HOME</b>		24a. REC'D BY REGISTRAR DATE <b>APR 26 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

4581  
MONTGOMERY  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04571

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Ma.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>20 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN</b>		d. STREET ADDRESS <b>5608 Wood May</b>	
3. NAME OF DECEASED (Type or print) <b>JAMES D. STUDLEY</b>		4. DATE OF DEATH Month Day Year <b>APRIL 21 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/26/92</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Wood Technologist</b>		9. AGE (In years last birthday) <b>68 yrs.</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>IOWA</b>	
13. FATHER'S NAME <b>William Judson STUDLEY</b>		14. MOTHER'S MAIDEN NAME <b>Annette LILLIE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>579-32-0561</b>	
17. INFORMANT <b>RUTH E. STUDLEY (WIFE)</b>		Address <b>SAME AS ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Contusions and lacerations</b> DUE TO (b) <b>Fall</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Cerebral Infarctions, left frontal &amp; Temporal lobes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>21 hours</b> <b>3-4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Reported to have fallen from ladder</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11:30 am. 7-20 1961</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Washington D.C.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Bruchart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BRUCHART</b>		DATE SIGNED <b>4-21-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/24/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Montgomery County, Maryland</b>	
23. FUNERAL DIRECTOR <b>The S.H. Hines Co. - 2901 14th St. N.W.</b>		ADDRESS <b>Washington 9, D.C.</b>	
24a. REC'D BY REGISTRAR <b>APR 24 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

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88

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RECEIVED

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(I)

1935-36-37

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
4582  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04572

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>(2)</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDITH ELIZABETH STULL</b>		4. DATE OF DEATH Month Day Year <b>APRIL 15 1961</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-2-89</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JOHN KEKKEAR Leishear</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH CHALK</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> DUE TO <b>49.1X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Toxic myocarditis</b> DUE TO (c) <b>Bronchopneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>5 days</b> <b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebrovascular accident with left hemiplegia - 1 month</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>July 9, 1948</b> to <b>April 15, 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>April 14, 1961</b> , and that death occurred at <b>9:27 A.M.</b> from the causes and on the date stated above.				
22a. SIGNATURE <b>Charles S. Whitaker</b>		22b. DATE SIGNED <b>4/15/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M.D.</b>		22d. ADDRESS <b>CLARKSVILLE, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-18-61</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel</b>		23d. LOCATION (City, town, or county) (State) <b>Scaggsville, Md</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>		25a. REC'D BY REGISTRAR DATE <b>APR 18 '61</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>				

0803

CERTIFICATE OF DEATH

1887

(M)

NAME OF DECEASED  
AGE  
SEX  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
SIGNATURE OF REGISTRAR  
OFFICE

(I)

DECLARATION OF DEATH  
I, the undersigned, being a duly qualified Medical Officer of Health for the District of ... do hereby certify that the above-named person died on the ... day of ... at the age of ... years, and that the cause of death was ...

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4583

04573

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville..</b> c. LENGTH OF STAY IN lb <b>38 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>908 Stonestreet, Ave.,</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville..</b> d. STREET ADDRESS <b>908 Stonestreet, Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>SHAIRMAN</b> Middle <b>R.</b> Last <b>SUMMEROUR</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>19 61</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1894</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months <b>66</b>	IF UNDER 24 HRS. Days <b>66</b>	Hours <b>66</b>	Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>			
13. FATHER'S NAME <b>Judge Summerour</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Allen</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>214-30-1346</b>		17. INFORMANT <b>Mrs. Ida Summerour 908 Stonestreet, Ave.,</b> <b>Rockville, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Central thrombosis</b> DUE TO (b) <b>central arteriosclerosis</b> DUE TO (c) <b>Hypertensive C-V Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>numia &amp; C.V.D.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>Indefinite</b> <b>@ 10 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2/1 1952</b> to <b>4/10/ 1961</b> , that (I) (we) last saw the deceased alive on <b>4/10/ 1961</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Stephen N. Jones MD</b>		22b. DATE <b>4/10/61</b>		22c. PHYSICIAN'S NAME (Type) <b>STEPHEN N. JONES MD</b>					
22d. ADDRESS <b>Rockville, Md</b>		22e. ADDRESS <b>Rockville, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/13/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park.,</b>		23d. LOCATION (City, town, or county) <b>Rockville, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Saraden</b>		ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate from the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04574

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN lb minutes <b>minutes</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Elmhurst Parkway</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>4413 Everett Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MATTIE</b> Middle <b>MALINDA</b> Last <b>SUMMERS</b>		4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 31, 1918</b>
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>2</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor of Supply</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt MIT</b>	
11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Lemmie Summers</b>		14. MOTHER'S MAIDEN NAME <b>X Zella McGill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Sister</b>		Address <b>Same as Item #2</b>	
17. INFORMANT <b>Mrs. Ralph Weber</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thoracic Hemorrhage</b> DUE TO <b>Bullet wound in left chest (heart)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>9776X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>self inflicted bullet wound in left chest</b>	
20c. TIME OF INJURY Month, Day, Year <b>3:50 p. m. 4/5/61</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, etc.) <b>street</b>	20f. (City or town) <b>Kensington</b> (County) <b>Montg.</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>April 5, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>	22b. DATE THEREOF <b>4-6-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>White Oak Cemetery</b>	22d. LOCATION (City, town, or county) <b>Oakdale, Tenn.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	
ADDRESS <b>Bethesda, Md.</b>		DATE <b>APR 10 '61</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
RACE [REDACTED]		BIRTH DATE [REDACTED]		BIRTH PLACE [REDACTED]	
OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]		EDUCATION [REDACTED]	
PRESENT ADDRESS [REDACTED]		DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF DECEASED [REDACTED]	
CERTIFICATE NO. [REDACTED]		EXAMINER'S NO. [REDACTED]		WITNESS NO. [REDACTED]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

Montgomery Co. Deputy Medical Examiner notified & released to hospital.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
4585									
04575									
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					b. COUNTY Montgomery				
c. LENGTH OF STAY IN 1b DOA					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital					d. STREET ADDRESS 4709 Bradley Blvd.				
3. NAME OF DECEASED (Type or print) First Middle Last Pauline Gertrude SWEET					4. DATE OF DEATH Month Day Year April 25 1961				
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-21-96		9. AGE (In years last birthday) 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (County & State, or foreign country) Tennessee			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Cumings					14. MOTHER'S MAIDEN NAME Bessie Harding				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No					17. INFORMANT (S) Richard B. Sweet, same as #2 above				
16. SOCIAL SECURITY NO.					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cor pulmonale acute</i> 241X DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Branchial asthma</i> (c) DUE TO cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 16, 1957 to April 24, 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 24, 1961, and that death occurred at 7:50AM, from the causes and on the date stated above.									
22a. SIGNATURE J. M. YOUNG, LT, MC, USN					22b. DATE SIGNED 4-25-61				
22c. PHYSICIAN'S NAME (Type) J. M. YOUNG, LT, MC, USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5-1-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City, town or county) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey					25a. REC'D BY REGISTRAR DATE APR 28 '61				
ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.					25b. REGISTRAR'S SIGNATURE Arthur S. Thayer				

(M)

(I)

U. S. Army General Hospital, Bethesda, Md.

U. S. Army General Hospital, Bethesda, Md.  
U. S. Army General Hospital, Bethesda, Md.  
U. S. Army General Hospital, Bethesda, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4588

04576

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton City-Rockville P.O.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton City -Rockville Post Office</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>12722 Robindale Drive</b>		d. STREET ADDRESS <b>12722 Robindale Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Anderson</b> Middle <b>H.</b> Last <b>Tackett</b>		4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/29/1881</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fed.Trade Comm.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Kentucky</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>King S.Tackett</b>	
14. MOTHER'S MAIDEN NAME <b>Rhoda Tackett</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs.Arthur Howard</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>diabetes mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>		21. I certify that (I) (this hospital) attended the deceased from <b>April 13, 1961</b> to <b>April 15, 1961</b> , that (I) <del>no</del> last saw the deceased alive on <b>April 12, 1961</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Stephen C. Cromwell</b>		22b. DATE SIGNED <b>4/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stephen C. Cromwell</b>		22d. ADDRESS <b>615 W. Montgomery Ave, Rockville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/18/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hims Co.</b>		25a. REC'D BY REGISTRAR <b>APR 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hims</b>		25c. ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bradley Blvd. &amp; Arlington Rd.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Denton</b> d. STREET ADDRESS <b>114 Edenton Lane</b>					
3. NAME OF DECEASED (Type or print) <b>William Edward Tawes</b>					4. DATE OF DEATH <b>April 6 1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/17/28</b>		9. AGE (In years last birthday) <b>32</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>St. Rds. Comm.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>W. Edward Tawes</b>					14. MOTHER'S MAIDEN NAME <b>Dorothy Revelle</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>Korean-1951-53</b>					16. SOCIAL SECURITY NO. <b>218-24-5044</b>					17. INFORMANT <b>Bar. 1</b>
18. CAUSE OF DEATH (Enter only one causa per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Crushed superior, extreme</b> 912-5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>sudden</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Caught behind bumper of crane and retaining wall</b>							
20c. TIME OF INJURY Month, Day, Year Hour <b>3:55</b> <b>4/6/61</b> p.m.			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) <b>Bethesda</b> (County) <b>Mont.</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Frank J. Broschart</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					Address (Street, city, town, or county) <b>4/6/61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/9/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sumneridge Mem. Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Cresfield Somerset Co. Md.</b>				
23. FUNERAL DIRECTOR <b>Bradshaw &amp; Son Funeral Home</b>					24a. REC'D BY REGISTRAR <b>APR 13 1961</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2588  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		c. LENGTH OF STAY IN 1b <b>10 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1310 VIERS MILL ROAD</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>	
3. NAME OF DECEASED (Type or print) <b>JAMES (Demetrios) THOMAS</b>		f. STREET ADDRESS <b>1310 VIERS MILL ROAD</b>	
4. DATE OF DEATH <b>APRIL 26 19 61</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 26, 1886</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
11. BIRTHPLACE (County & State, or foreign country) <b>Assenograd, Bulgaria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>357-07-5844</b>	
17. INFORMANT <b>Mrs. Timothy B. Riley, 1310 Viers Mill Road</b>		Address <b>Rockville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro vascular accident</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10-15 min</b> <b>15-20 yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>e.m.</b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>11-23</b> , 19 <b>57</b> , to <b>4-26</b> , 19 <b>61</b> , that (I) ( <del>the</del> ) last saw the deceased alive on <b>3-18</b> , 19 <b>61</b> , and that death occurred <b>2:27</b> PM, from the causes and on the date stated above.			
22a. SIGNATURE <b>W. G. Hall</b> M.D.		22b. DATE SIGNED <b>4/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. G. HALL</b>		22d. ADDRESS <b>615 W MONTGOMERY AVE ROCKVILLE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/28/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. PUMPHREY, INC. SILVER SPRING, MD.</b> <b>Raymond A. Ziska</b>		25a. REC'D BY REGISTRAR <b>MAY 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]  
TIME: [Illegible]  
PLACE: [Illegible]

BY: [Illegible]  
FOR: [Illegible]

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4589

04579

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY in b. <u>13 hrs.</u>		d. STREET ADDRESS <u>6007 Johnson Ave.,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>AZMELIAN</u> Last <u>TURMANIAN</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/19/1893</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Malatia, Armenin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hovanes Tutelian</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kevorkian</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes, no, or unknown)</u>		16. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>	
17. INFORMANT <u>Armenie Turmanian (daughter-in-law)</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION AND MYOCARDIAL INFARCTION</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> , 19 <u>61</u> , to <u>4/18</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4/17</u> , 19 <u>61</u> , and that death occurred at <u>4:45</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>B. Mangasarian</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>B. MANGASARIAN</u>		22b. DATE SIGNED	
22d. ADDRESS <u>2801 Wisconsin Ave. NW.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>april 21, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home Wash. DC.</u>		25a. REC'D BY REGISTRAR <u>APR 21 '61</u>	
ADDRESS <u>4812 G. Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

(M)

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13 Dec.

1000 Johnson Ave.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4590

04580

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>6 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u> d. STREET ADDRESS <u>502 Comer Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Minerva (NMN) Van Cleef</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-76</u> yrs. <u>85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE (In years last birthday) <u>85</u> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Morris</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Sgt. Frederick Van Cleef</u> Address <u>5202 Carriage Dr., Washington, D.C.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CONGESTIVE HEART FAILURE</u> (a), stating the underlying cause last. (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> 3 mos. 4-5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 15, 1961</u> to <u>APRIL 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>APRIL 6, 1961</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>David D. [Signature]</u>		22b. DATE SIGNED <u>4/6/61</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>Harold [Signature]</u>		22d. ADDRESS <u>1352 UNIVERSITY LANE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<u>TRANS. &amp; BURIAL</u>	<u>4/10/61</u>	<u>HAMILTON CEMETERY</u>	<u>MONMOUTH COUNTY, NEW JERSEY</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Jucka</u>		25a. REC'D BY REGISTRAR <u>APR 11 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(I)

THOMAS A. WATSON, JR.,  
SILVER SPRING, MD.  
WASHINGTON COUNTY, NEW JERSEY

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RECORDS AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4591

04581

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47 X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium &amp; Hospital</u> 5721 Grosvenor Lane				d. STREET ADDRESS <u>5237 Nebraska Ave., N.W.</u>			
3. NAME OF DECEASED (Type or print) (Mrs) <u>Ida Grant</u> First Middle Last <u>Van Slyke</u>				4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-20-1865</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>#1</u> <u>Records at Resmor Sanitarium &amp; Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular collapse</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO 2 yrs. (c) <u>none</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/11</u> 19 <u>61</u> to <u>4/19</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4/18</u> 19 <u>61</u> , and that death occurred at <u>12:20</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D.				22b. DATE SIGNED <u>4/19/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut</u>				22d. ADDRESS <u>4890 Battery Lane, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/19/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.-2901 14th St., N.W.</u>				25a. REC'D BY REGISTRAR <u>APR 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

(M)

(T)



4592

CERTIFICATE OF DEATH

Reg. Dist. No. 04582

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 09	
c. LENGTH OF STAY IN 1b <u>63 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>314 E Montgomery Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Irene Victoria Agatha Viet</u>		4. DATE OF DEATH <u>April 19 1961</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 22, 1877</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry van der von Oomkens</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Frye</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Daughter - Mrs Dorothy Smith</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured atheromatous plaque</u> (c) <u>4-5 days</u> 4-5 days 4-5 days		INTERVAL BETWEEN ONSET AND DEATH 4-5 days 4-5 days 4-5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 1956</u> to <u>April 19 1961</u> , that I last saw the deceased alive on <u>April 19 1961</u> and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Corinne Cooper</u> M.D.		ADDRESS (Street, city or town, state) <u>104 S Washington St Rockville Md.</u>	
PHYSICIAN'S NAME (Type) <u>Corinne Cooper</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>4/22/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>		24a. REC'D BY REGISTRAR <u>APR 24 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4745

Item 1 Film G305 1/9/62 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 04732

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellsville, Md.</u>	
c. LENGTH OF STAY IN 1b <u>1 week</u>		d. STREET ADDRESS <u>--</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Johnsons Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LUDWIG</u>		4. DATE OF DEATH <u>APRIL 21 1961</u>	
5. SEX <u>white male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 2, 1882</u>	
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Ludwig Voll</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Bauer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
INFORMANT <u>Alfred J Heine Bowie, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>199X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 15, 1961</u> , to <u>April 21, 1961</u> , that I last saw the deceased alive on <u>April 20, 1961</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. F. Thibadeau</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10115 Columbia Rd. 4/21/61</u>	
PHYSICIAN'S NAME (Type) <u>A. F. THIBADEAU</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D C</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

100-100000

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

EDUCATION: [illegible] OCCUPATION: [illegible]

RELIGION: [illegible] MARRIED: [illegible]

DECEASED'S ADDRESS: [illegible]

DECEASED'S PHONE: [illegible]

DECEASED'S SOCIAL SECURITY NUMBER: [illegible]

DECEASED'S MARITAL STATUS: [illegible]

DECEASED'S RACE: [illegible]

DECEASED'S ETHNIC ORIGIN: [illegible]

DECEASED'S SEX: [illegible]

DECEASED'S AGE: [illegible]

DECEASED'S DATE OF BIRTH: [illegible]

DECEASED'S PLACE OF BIRTH: [illegible]

DECEASED'S CAUSE OF DEATH: [illegible]

DECEASED'S DATE OF DEATH: [illegible]

DECEASED'S PLACE OF DEATH: [illegible]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

4593

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04583

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>MONTG</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>18</u> YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1307 BALTIMORE AVE.</u>				d. STREET ADDRESS <u>1307 BALTIMORE AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>DONALD D. WALLACE</u>				4. DATE OF DEATH Month Day Year <u>APRIL 5, 1961</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1908</u>		9. AGE (In years lost birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insulator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insulating</u>		11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Donald M. Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Jessie Sorbus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Mrs. Naomi E. Wallace (same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> <u>355X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Extensive Cerebral Strophy</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1946</u> to <u>5-Apr.</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4 Apr.</u> 19 <u>61</u> , and that death occurred at <u>7:18</u> A. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>M. B. Queen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-Apr 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. B. QUEEN M.D.</u>				22d. ADDRESS <u>7112 Willow Ave TAKOMA PARK, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 7, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Arthur Walters, 254 Carroll St NW D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>	

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CERTIFICATE OF DEATH

11554

(M)

(1)

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]  
11. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4594

4584

4594

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	c. LENGTH OF STAY IN 1b <b>14 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>809 GIST AVENUE</b>		d. STREET ADDRESS <b>809 GIST AVENUE</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>WALTER</b> Last <b>WALLINGSFORD</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>16</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/22/72</b>
9. AGE (In years lost birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BRIDGE CONSTRUCTION</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PENN. RAILROAD</b>	11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM WALLINGSFORD</b>	
14. MOTHER'S MAIDEN NAME <b>ELLA ROSE unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Mrs. Ruth P. Wallingsford, wife 809 Gist Ave., Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Feb 10, 1958</b> to <b>April 16, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 12, 1961</b> , and that death occurred at <b>5:57 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Aaron H. Traum</b>		22b. DATE SIGNED <b>April 17, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>AARON H. TRAUM</b>		22d. ADDRESS <b>8237 GA. AVE., SILVER SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/18/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CONGRESSIONAL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</b> <b>Raymond A. Giska</b>		25a. REC'D BY REGISTRAR DATE <b>APR 19 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Traut</b>			

OFFICE OF THE ATTORNEY GENERAL  
STATE OF MARYLAND  
BALTIMORE, MARYLAND

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4595

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04585

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
c. LENGTH OF STAY IN 1b <u>6 weeks</u>		d. STREET ADDRESS <u>3524 "B" St., S.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u> 2623 Newton St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>E</u> Last <u>WARME</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5, 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	11. BIRTHPLACE (State or foreign country) <u>SWEDEN</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Mons MAGNUSON</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>  </u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT (SON) <u>JOHN A. WARME</u> Address <u>SILVER SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS.</u> <u>15 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of right femur &amp; humerus (FALL)</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1961</u> to <u>April 7, 1961</u> ; that (I) (we) last saw the deceased alive on <u>April 6, 1961</u> , and that death occurred at <u>2 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Belden R. Reap Md.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>April 7, 1961</u>
22c. PHYSICIAN'S NAME (Type) <u>BELDEN R. REAP</u>		22d. ADDRESS <u>11502 Grandview Ave., Wheaton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>4/8/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Versailles Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>McKeesport, Pa.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		25a. REC'D BY REGISTRAR <u>  </u> DATE <u>APR 10 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Orlino S. Hines</u>

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UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1903

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4596  
MONTGOMERY  
4586

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrett Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Sanitarium</i>		d. STREET ADDRESS <i>11016 Rokeby Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>BESSIE Bower</i>		4. DATE OF DEATH <i>APRIL 15 1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>23 Feb. 1888</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>William H. Bower</i>		14. MOTHER'S MAIDEN NAME <i>Bessie Rich.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes Unknown</i>	
17. INFORMANT <i>Mrs. Elizabeth W. Crichton</i>		Address <i>Same as Item 2.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>493X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis. Arteriosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <i>Nov. 1958</i> to <i>April 15, 1961</i> , that (I) <del>the</del> last saw the deceased alive on <i>April 15, 1961</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Seruch T. Kimble</i>		22b. DATE SIGNED <i>4-16-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>SERUCH T. KIMBLE</i>		22d. ADDRESS <i>929 Pershing Drive Silver Spring Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>4-17-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City, town, or county) (State) <i>Prince George Co., Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>		25a. REC'D BY REGISTRAR <i>Bethesda, Md.</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		DATE <i>APR 19 '61</i>	

CENTRAL OF DEATH

1964

11-10-64

Memorandum

Subject

Re

Reference

INTERNAL SECURITY

CONFIDENTIAL

TO : DIRECTOR, FBI (100-388610)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED]

RE: [REDACTED]

1. [REDACTED]

2. [REDACTED]

3. [REDACTED]

4. [REDACTED]

5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>42 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>48X-3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Dora</b> d. STREET ADDRESS <b>1305 Crestview Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hannah</b> Middle <b>Haines</b> Last <b>Webb</b>				4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 12, 1889</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>0</b> Hours <b>0</b> Min.		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Alanson Haines</b>				14. MOTHER'S MAIDEN NAME <b>Clara Wiswill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Unavailable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral Neoplasm</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>193.0</b> (c) <b>9 Months</b> INTERVAL BETWEEN ONSET AND DEATH <b>9 Months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>193.0</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 19, 19 61</b> , to <b>April 2, 19 61</b> , that (I) (we) lost saw the deceased alive and <b>April 2, 19 61</b> , and that death occurred at <b>9:15 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Michael W. Brandriss</b> 22c. PHYSICIAN'S NAME (Type) <b>MICHAEL W. BRANDRISS, M.D.</b>				22b. DATE SIGNED <b>4-3-61</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 4-3-61</b>		23b. DATE THEREOF <b>4-3-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Newfields Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Newfields, New Hampshire</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b> ADDRESS <b>Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>APR 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Krome</b>	

23

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04588											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					
c. LENGTH OF STAY IN b. <b>4 days</b>						d. STREET ADDRESS <b>7805 Overhill Road</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Frances Adele Wenger</b>						4. DATE OF DEATH <b>April 6 1961</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>Wh</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 15, 1873</b>		9. AGE (In years last birthday) <b>88 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hwf.</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>					
11. BIRTHPLACE (County & State, or foreign country) <b>Louisiana</b>						12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
13. FATHER'S NAME <b>Louis A. Roussel</b>						14. MOTHER'S MAIDEN NAME <b>Amelie Corney</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>Ruth Wenger Dawson (Daughter)</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Failure</b> (c) <b>Arteriosclerotic Heart Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>10 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <b>None</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1961</b> , to <b>April 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 6, 1961</b> , and that death occurred at <b>11:30</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>William H. Killay</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>4/6/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>William H. Killay</b>						22d. ADDRESS <b>5218 Wisconsin Ave</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4/11/61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>						ADDRESS <b>Bethesda, Maryland</b>			25a. REC'D BY REGISTRAR <b>APR 12 '61</b>		
									25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		

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JOHN ROBERT HUNTER A. ROBERTS  
JAMES ROBERT HUNTER A. ROBERTS  
JAMES ROBERT HUNTER A. ROBERTS

Robert A. Fumagalli, Maryland  
Book Creek Cemetery, Washington, D. C.

TO HOSPITAL. The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04589

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>40 Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>10202 Menlo Ave.</b>		d. STREET ADDRESS <b>10202 Menlo Ave.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Gertrude May Whipple</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>16</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>July ? 1873</b>
<b>9. AGE</b> (In years last birthday) <b>87 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>4</b> Days <b>5</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Housewife</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>New York State</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Henry Rufus Wood</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth D. Burton</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>---</b>		<b>16. SOCIAL SECURITY NO.</b> <b>---</b>	
<b>17. INFORMANT</b> <b>Calvin E. Whipple</b>		<b>Address</b> <b>10202 Menlo Ave.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>4-5 yrs</b> <b>?</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1/27</b> , 19 <b>61</b> to <b>4/16</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/14</b> , 19 <b>61</b> , and that death occurred at <b>4/16</b> M, from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>William D. And MD</b>		<b>22b. DATE SIGNED</b> <b>4/17/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>WILLIAM D. AND</b>		<b>22d. ADDRESS</b> <b>906 Glenville Rd Silver Spring Md</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Cremation</b>	<b>23b. DATE THEREOF</b> <b>April 20, 1961</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cemetery</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Suitland Md.</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Deal Funeral Home</b>		<b>25a. REC'D BY REGISTRAR</b> <b>APR 21 '61</b>	
<b>ADDRESS</b> <b>4812 Georgia Ave. N. W.</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Harris</b>	

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Don't forget to call 100-1000  
Don't forget to call 100-1000  
Don't forget to call 100-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4600

04590

<b>1. PLACE OF DEATH</b> a. COUNTY Montgomery				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE Colorado			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Durango			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS - - - - -			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last James Hudson WIGGLESWORTH				<b>4. DATE OF DEATH</b> Month Day Year April 4 19 61			
<b>5. SEX</b> Male		<b>6. COLOR OR RACE</b> Caucasian		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> 12-3-07	
<b>9. AGE</b> (In years last birthday) 53 yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Foreign Service Officer Dept. of State				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Colorado		<b>11. BIRTHPLACE</b> (County & State, or foreign country) USA	
<b>13. FATHER'S NAME</b> William Hudson WIGGLESWORTH				<b>14. MOTHER'S MAIDEN NAME</b> Almeda MC EWEN			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) Yes 1941 to 1946				<b>16. SOCIAL SECURITY NO.</b> (W) Mrs. Thelma Wigglesworth, 4447 Albemarle St.			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO (b) <i>Metastatic adenocarcinoma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 months			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 6 19 61 to April 4 19 61, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 4 19 61, and that death occurred at 9:05 PM, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <i>Kenneth F. Spence, Jr.</i>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> 4-5-61	
<b>22c. PHYSICIAN'S NAME</b> (Type) Kenneth F. SPENCE, JR., LT, MC, USNU. S. Naval Hospital, Bethesda, Md.				<b>22d. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial		<b>23b. DATE THEREOF</b> 4-7-61		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Arlington National		<b>23d. LOCATION</b> (City, town or county) (State) Arlington Virginia	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Cheryl E. Hume</i>				<b>ADDRESS</b> Chevy Chase Funeral Home, 5103 Wisc. Ave, NW, Wash DC		<b>25a. REC'D BY REGISTRAR</b> APR 10 '61	
				<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hume</i>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04591

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b <b>1 yr., 11 mos.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>EVENTIDE NURSING HOME</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>1903 PERSHING DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA MINERVA WILLIAMS</b>		4. DATE OF DEATH Month Day Year <b>APRIL 24 1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/30/79</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (County & State, or foreign country) <b>KANSAS</b>
13. FATHER'S NAME <b>JAMES BOYD</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT Address <b>Mr. Frank H. Williams, 703 McNeill Road Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446X</b> <b>uremia</b> DUE TO (b) <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>hypertension</b> DUE TO (c) <b>hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>arteriosclerotic heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>3 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 24, 1961</b> to <b>April 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 24, 1961</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Samuel T. Kimble, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>25 Apr '61</b>
22c. PHYSICIAN'S NAME (Type) <b>Seruch T. Kimble, M. D.</b>		22d. ADDRESS <b>927 Pershing Dr. Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4/27/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT HILL CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>WASHINGTON, D.C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>WERNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	25a. REC'D BY REGISTRAR <b>APR 28 1961</b> DATE
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **04592**

**4602**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dickerson (Rural)</b>		c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Dickerson (Rural)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MAURICE</b> Middle <b>MELVIN</b> Last <b>WILLIAMS</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>15</b> Year <b>1961</b>			
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>A. A.</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>B. DATE OF BIRTH</b> <b>Jan. 12, 1888</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>73</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Thomas J. Williams</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Nannie Betters</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>W.W. # 1 217-10-9885</b>		<b>INFORMANT</b> Address <b>Sadie Williams-- Dickerson, Md. R. F. D. 2</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral vascular accident</b> <b>592X</b> DUE TO (b) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Chronic glomerular nephritis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>2 years</b> <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right hemiplegia</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from June 1958, to April 15, 1961, that I last saw the deceased alive on April 6, 1961, and that death occurred at 10:00 AM, from the causes and on the date stated above.</b>							
<b>ACTUAL SIGNATURE</b> <b>John G. Lawrence</b> M.D.				<b>ADDRESS</b> (Street, city or town, state) <b>Dawsonville</b> <b>DATE SIGNED</b> <b>4/15/61</b>			
<b>PHYSICIAN'S NAME (Type)</b> <b>JOHN LAWRENCE</b>				<b>P.O. Box, Maryland</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>4/18/61</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Warren Chapel.</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Martinsburg, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert L. Swindle</b>				<b>ADDRESS</b> <b>Rockville, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>APR 20 '61</b>	
				<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thayer</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4603

## CERTIFICATE OF DEATH

04593

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>24 Silver Spring</u> d. STREET ADDRESS <u>1700 Sligo Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>William Florizo Williams</u>		<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>11</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Cauc.</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>83</u> <u>9-28-1877</u>		<b>9. AGE</b> (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farmer</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>North Carolina</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>George Williams</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Millie Ann Moore</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>229-32-9558</u> <b>17. INFORMANT</b> <u>Son - Mr. George Williams</u> Address <u>700 Sligo Ave. Silver Spring, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Renal calculi</u> (c) <u>chronic pyelonephritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (e) <u>  </u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>4/7</u> , 19 <u>61</u> , to <u>4/11</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4/11</u> , 19 <u>61</u> , and that death occurred at <u>6:25</u> M., from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Arthur J. Wilets</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>ARTHUR J. WILETS</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>1015 Spring St., Silver Spring, Md.</u> <b>22b. DATE</b> <u>4/11/61</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>4/13/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>High Hill Baptist Church Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Jarratt, Sussex County, Va.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>APR 19 '61</u> DATE		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur J. Wilets</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4604

04594

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksburg..</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>H.</b> Last <b>WIMS</b>				4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>19 61</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1882</b>		9. AGE (In years last birthday) <b>76</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Warner Wims</b>				14. MOTHER'S MAIDEN NAME <b>Marie E. Duffin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. Altia M. Wims.</b> Address <b>Clarksburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of prostate with generalized metastases</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 177X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> 19 <b>61</b> , to <b>4/12</b> 19 <b>61</b> , that (I) (we) lost saw the deceased alive on <b>4/11</b> 19 <b>61</b> , and that death occurred at <b>4/15</b> 19 <b>61</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>James P. Kerr</b>				22b. ADDRESS <b>DAIMASCUS, Md.</b>		22c. DATE SIGNED <b>4/15/61</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. James P. Kerr</b>				22e. ADDRESS <b>DAIMASCUS, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rocky Hill..</b>		23d. LOCATION (City, town, or county) (State) <b>Clarksburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Swords</b>				25a. REC'D BY REGISTRAR <b>APR 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

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1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4605  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04595

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>Since Nov. '60</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10,306 BRUNSWICK AVE.</b>		d. STREET ADDRESS <b>10,306 BRUNSWICK AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>NEWTON</b> Last <b>WOLFE</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>8</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/22/79</b>
9. AGE (In years lost birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAGGAGE AGENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RR Express Agency</b>	
11. BIRTHPLACE (State or foreign country) <b>Ijamsville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE WOLFE</b>		14. MOTHER'S MAIDEN NAME <b>GEORGIANNA CLAY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>714-07-9398</b>	
17. INFORMANT <b>Mrs. Charles J. Miller, 10,306 Brunswick Ave. Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute uremia</b> 442X DUE TO <b>Cardio-vascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Generalized arteriosclerosis</b> (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral pulmonary emphysema Prostatic hypertrophy</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>12 years</b> <b>12 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 7, 1961</b> to <b>8 April 1961</b> , that (I) (we) last saw the deceased alive on <b>7 April 1961</b> , and that death occurred at <b>A. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>C. Roger Kurtz, M.D.</b>		22b. DATE SIGNED <b>4-8-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. Roger Kurtz, M.D.</b>		22d. ADDRESS <b>3701 Gun. Ave. NW. D.C.</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/12/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S CATHOLIC CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PUMPHREY, INC. Raymond A. Zicka</b>		25a. REC'D BY REGISTRAR DATE <b>APR 13 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneiss</b>			

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NEW YORK CITY DEPARTMENT OF POLICE

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TO HOSPITAL OR A DEDICATED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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4606  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAMASCUS	
d. STREET ADDRESS 25111 RIDGE ROAD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last MAZIE MARIE WOODFIELD		4. DATE OF DEATH Month Day Year APRIL 27, 19 61	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-27-1890	
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN WATKINS		14. MOTHER'S MAIDEN NAME EVIE LEE KING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-36-6962	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Myocardial Infarction DUE TO (b) Coronary arteriosclerosis (c) Mesenteric Artery Thrombosis with bowel necrosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STAGING THE UNDERLYING CAUSE LOST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Diabetic Mellitus, Severe Hypertension, Renal Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH: 10 yrs 5 days	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1953 to 4/27 1961, that (I) (we) last saw the deceased alive on 4/27 1961 and that death occurred at 11:10 AM, from the causes and on the date stated above.			
22a. SIGNATURE G. F. MEADORS, MD		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) G. F. MEADORS, MD		22d. ADDRESS DAMASCUS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-30-61	
23c. NAME OF CEMETERY OR CREMATORY Upper Seneca Baptist		23d. LOCATION (City, town, or county) (State) Cedar Grove, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR DATE MAY 2, '61	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04597

<b>1. PLACE OF DEATH</b> a. COUNTY Montgomery			<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE Maryland			b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 10 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital			d. STREET ADDRESS 10329 Bethesda Church Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) Kenneth Jack YOUNG			<b>4. DATE OF DEATH</b> Last April 18 1961			Month Day Year		
<b>5. SEX</b> Male			<b>6. COLOR OR RACE</b> Caucasian			<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		
<b>8. DATE OF BIRTH</b> 2-16-19			<b>9. AGE</b> (In years last birthday) 42 yrs.			IF UNDER 1 YEAR Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Electronic Technician			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> U. S. Govt.			<b>11. BIRTHPLACE</b> (County & State, or foreign country) West Virginia		
<b>13. FATHER'S NAME</b> George W. YOUNG			<b>14. MOTHER'S MAIDEN NAME</b> Mary HARR			<b>12. CITIZEN OF WHAT COUNTRY?</b> USA		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) Yes			<b>16. SOCIAL SECURITY NO.</b> 1944 to 1946			<b>17. INFORMANT</b> Address (W) Mrs. Ethel V. Young, same as #2 above		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic heart disease with DUE TO (b) aneurysm ascending aorta and aortic insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		
<b>20f. (City or town)</b> (County) (State)								
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 18, 1961, to April 28, 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 28, 1961, and that death occurred at 1:45 PM, from the causes and on the date stated above.								
<b>22a. SIGNATURE</b> J. E. MC CLENATHAN			<b>22b. DATE SIGNED</b> 4-28-61					
<b>22c. PHYSICIAN'S NAME</b> (Type) J. E. MC CLENATHAN, CDR, MC, USN			<b>22d. ADDRESS</b> U. S. Naval Hospital, Bethesda, Md.					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial - Transit			<b>23b. DATE THEREOF</b> 4-29-61			<b>23c. NAME OF CEMETERY OR CREMATORY</b> Berkeley Springs Cemetery		
<b>23d. LOCATION</b> (City, town or county) Berkeley Springs			<b>23e. (State)</b> W. Virginia					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> R. A. Humphrey			<b>24b. ADDRESS</b> Home, Bethesda, Md.			<b>25a. REC'D BY REGISTRAR</b> DATE MAY 2 '61		
<b>25b. REGISTRAR'S SIGNATURE</b> Arthur S. Kraus								

04537

100

U. S. Government  
Department of the Interior  
Bureau of Land Management  
Washington, D. C.  
April 10, 1951  
Mr. J. H. ...  
...

April 10, 1951  
Mr. J. H. ...  
...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4608

04598

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5902 BEECH AVE.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>45</u> d. STREET ADDRESS <u>5902 BEECH AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>PHILIP L. ZEIGLER</u>		<b>4. DATE OF DEATH</b> Month <u>APRIL</u> Day <u>12</u> Year <u>1961</u>					
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>CAUCASOID</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Aug. 3, 1894</u>	<b>9. AGE</b> (In years last birthday) <u>66</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>8</u> Days <u>9</u> Hours <u></u> Min. <u></u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired-Salesman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Brystal Myers</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pennsylvania</u>			
<b>13. FATHER'S NAME</b> <u>George Albert Zeigler</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary (Unknown)</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>083-05-7524</u>		<b>17. INFORMANT</b> <u>Mae M. Zeigler-Wife-Same 2d</u> Address <u></u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (c) <u>CORONARY ATHEROSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <u>FEB 23, 1961</u> <u>9:00 PM</u> <b>to</b> <u>APRIL 11, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>APRIL 11, 1961</u> <b>and that death occurred at</b> <u>9:00 PM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Joseph D. Connor</u>		<b>22b. DATE SIGNED</b> <u>April 12, 1961</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>JOSEPH D. CONNOR, M.D.</u>			
<b>22d. ADDRESS</b> <u>9420 OLD GEORGETOWN RD Bethesda 14 Maryland</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4/15/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Rockville, Maryland</u>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>		<b>ADDRESS</b> <u>Bethesda, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>APR 17 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Kraus</u>							

VR A15 (4)  
15M 9/60

(M)

(I)

George Albert Reiser

Mary (Hickson)

003-00-1524 See M. Reiser-Hickson 2d

ROUTE MYC REPAIR ILLINOIS

CHICAGO ILLINOIS

CONSTRUCTION PATENT OFFICE

April 11, 1911  
J. D. Reiser  
J. D. Reiser, Inc.  
1250 N. Dearborn St.  
Chicago, Ill.

Robert A. Ruppert, Bethesda, Maryland  
William A. Ruppert, Bethesda, Maryland  
William A. Ruppert, Bethesda, Maryland

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
4609									
04599									
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN 1b 2 days				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					d. STREET ADDRESS Mt. Ranier 2706 Upshur St.				
3. NAME OF DECEASED (Type or print) David					4. DATE OF DEATH Month Day Year April 26 19 61				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-24-61		9. AGE (In years last birthday) yrs. Months Days 2 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -					10b. KIND OF BUSINESS OR INDUSTRY -			11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Lewis Henry ZIELSDORF					14. MOTHER'S MAIDEN NAME Arla Mae RADUE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. None				
17. INFORMANT (F) Lewis H. Zielsdorf, same as #2 above					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from April 24 1961, to April 26 1961 that (X) (we) last saw the deceased alive on April 26 1961, and that death occurred at 9:30AM, from the causes and on the date stated above.									
22a. SIGNATURE H. A. PEARSON LCDR MC USN					22b. DATE SIGNED 4-26-61				
22c. PHYSICIAN'S NAME (Type) H. A. PEARSON LCDR MC USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment			23b. DATE THEREOF 4-27-61		23c. NAME OF CEMETERY OR CREMATORY Irving Township Cemetery			23d. LOCATION (City, town or county) (State) Black River Falls Wisconsin	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey					ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR APR 28 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna

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(M)

(I)

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P. C.

Washington

Mr. [illegible]

2100 [illegible]

WASHINGTON

4-24-41

My [illegible]

Dear [illegible]

(X) [illegible] [illegible]

Yours

[illegible]

April 24, 1941

Mr. [illegible]  
[illegible]

Very truly yours,  
[illegible]  
[illegible]  
[illegible]